BOB Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

System Plan submission – 27 September 2019

DRAFT Strategic Delivery Plan (system narrative)

BOB ICS - introduction

BOB Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

About us

Together, we serve a total of 1.8 million people, stretching from Banbury in the North to Wokingham/Riseley in the South, from Hungerford in the West to Amersham in the East. Our composition is more fully described on page 5.

Our population is one the fastest growing in the country, predicted to increase by almost 25% by 2033 – and more, as the ambition of what is known as the Oxfordshire-Cambridge ARC to stimulate economic growth, research and business opportunities for the area is realised. We are ambitious for the communities we serve.

We want to prevent ill health, improve care for patients and reduce pressure on staff but face a significant challenge to make the best use of the funding available to us to meet current and future health and care needs, particularly given the population growth we expect to see. By working together, we will be in the best position to maximise this opportunity, while making sure our health and care services are fit for such a promising future.

Our aims:

- To work together to deliver joined up health and care services based on the needs of individuals and shaped by the circumstances and priorities of local communities
- To support people to live longer, healthier lives and treat avoidable illness early on
- To make the best use of limited public funds and resources so that, together, we can secure the best outcomes
- To make our focus local unless it is more efficient and effective for us to pool our expertise and resources to work together as an integrated health and care system across Buckinghamshire, Oxfordshire and Berkshire West (BOB).
- To reach out, where appropriate, beyond our borders and work in partnership with others – for example, across the wider Thames Valley region on specialist cancer services.

There are many positives about people, places and services in BOB

People are generally healthier than in other parts of the country

- People live longer
- Diabetes cases are far lower across the area
- Lower smoking rates than the national average
- Adult obesity rates are below the national average
- There are lower rates of many major diseases compared to the national average including cancer, dementia and stroke

The quality of care provided is recognised by national regulators and by the people we serve

- Many of our services are rated well by the Care Quality Commission (CQC), providing good overall quality of care.
- People have told us that, when they do receive services, staff are compassionate and caring
- People have told us that their experience of specialist teams (cancer treatment, heart failure services or MacMillan staff) has been good

We are at the forefront of advances in digital technology

- We are part of the Thames Valley and Surrey Care Records Partnership – connecting local records across the region so that people can benefit from more joined up care
- We have a number of “Global Digital Exemplars”, delivering improvements in the quality of care, through world=-class digital technologies

We cover an area with strong infrastructure that is predicted see significant economic growth, bringing with it an increase people living in the area

- We have a number of highly regarded medical schools, universities and biomedical research centres
- There is strong investment in research, development and innovation, including over 500 life sciences businesses with major strengths in medical diagnostics and digital innovation
- There will be significant investment in business and infrastructure (including transport links) over the coming years

BOB ICS – introduction (cont.)

BOB Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

But there are challenges to overcome

Although, on the whole, people have good health, it is not the case for everyone

- Parts of Oxford, Banbury, Aylesbury and Reading are in the 20% most deprived areas of the UK. In these areas there are higher levels of:
- Homelessness
- Childhood obesity
- Diabetes
- Falls in elderly people
- Smoking rates amongst people with anxiety and depression

50% of people living in the Buckinghamshire, Oxfordshire and Berkshire West area have **one or more long term condition**.

There is a higher number of premature deaths of people with serious mental illness compared to the national average

Some services are struggling to meet demand

- Our hospitals have not met the 95% A&E target
- Demand for our services is in some cases exceeding our individual capacity to provide them for several specialties and this gap is expected to grow
- People have told us that they continue to find it difficult to get a GP appointment
- People have told us that they are waiting too long from referral to treatment
- People have told us that they or their loved ones are waiting too long to receive a number mental health services, particularly for Child Adolescent Mental Health Services (“CAMHS”)
- The estimated 25% population growth will add new pressures on services

We, along with independent and voluntary sector service providers, have difficulty recruiting and retaining staff across the BOB health and social care system. This is due to the high cost of living and competitive local jobs markets

- The cost of both purchasing and renting accommodation is high across our area
- Nursing staff are likely to have to spend 58% of their monthly salary on housing
- The average price of housing in the BOB ICS area is 70% higher than the national average price of housing
- Our care workers tell us they would leave sector/area for jobs that enable them to buy family homes

There is significant house building in some areas of our system but in other locations, building is restricted - which can limit the availability of rented accommodation and social housing. It also means that, if staff can’t find homes closer to where they work, their journey time is increased, adding an additional cost

Many of our areas have high employment rates, which is a great success but makes attracting people to health and care jobs more challenging

Our buildings and medical equipment are becoming outdated

- We face a challenge to maintain our buildings to keep them fit for purpose
- Our equipment does not always keep up with advances in technology

BOB ICS – composition & governance

BOB Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Composition of the BOB ICS

The Buckinghamshire, Oxfordshire and Berkshire West ICS comprises a large number of NHS Trusts, Clinical Commissioning Groups, and Local Authorities (see table below) as well as federations and Health & Wellbeing Boards.

	NHS Providers	Clinical Commissioning Groups	Local Government
Bucks	• Buckinghamshire Healthcare NHS Trus • Oxford Health NHS Foundation Trust • South Central Ambulance Service NHS Foundation Trust • FedBucks GP Federation • Medicas Health (North Buckinghamshir GP Federation)	• NHS Buckinghamshire CCG	• Buckinghamshire County Council
Oxfordshire	• Oxford University Hospitals NHS Foundation Trust • Oxford Health NHS Foundation Trust • SouthCentral Ambulance Service NHS Foundation Trust	• NHS Oxfordshire CCG	• Oxfordshire County Council
Berks West	• Royal Berkshire Hospital • Berkshire Healthcare Foundation Trust • South Central Ambulance Service NHS Foundation Trust • GP Neighbourhood Alliances	• NHS Berkshire West CCG	• Reading Borough Council • Wokingham Borough Council • West Berkshire Council

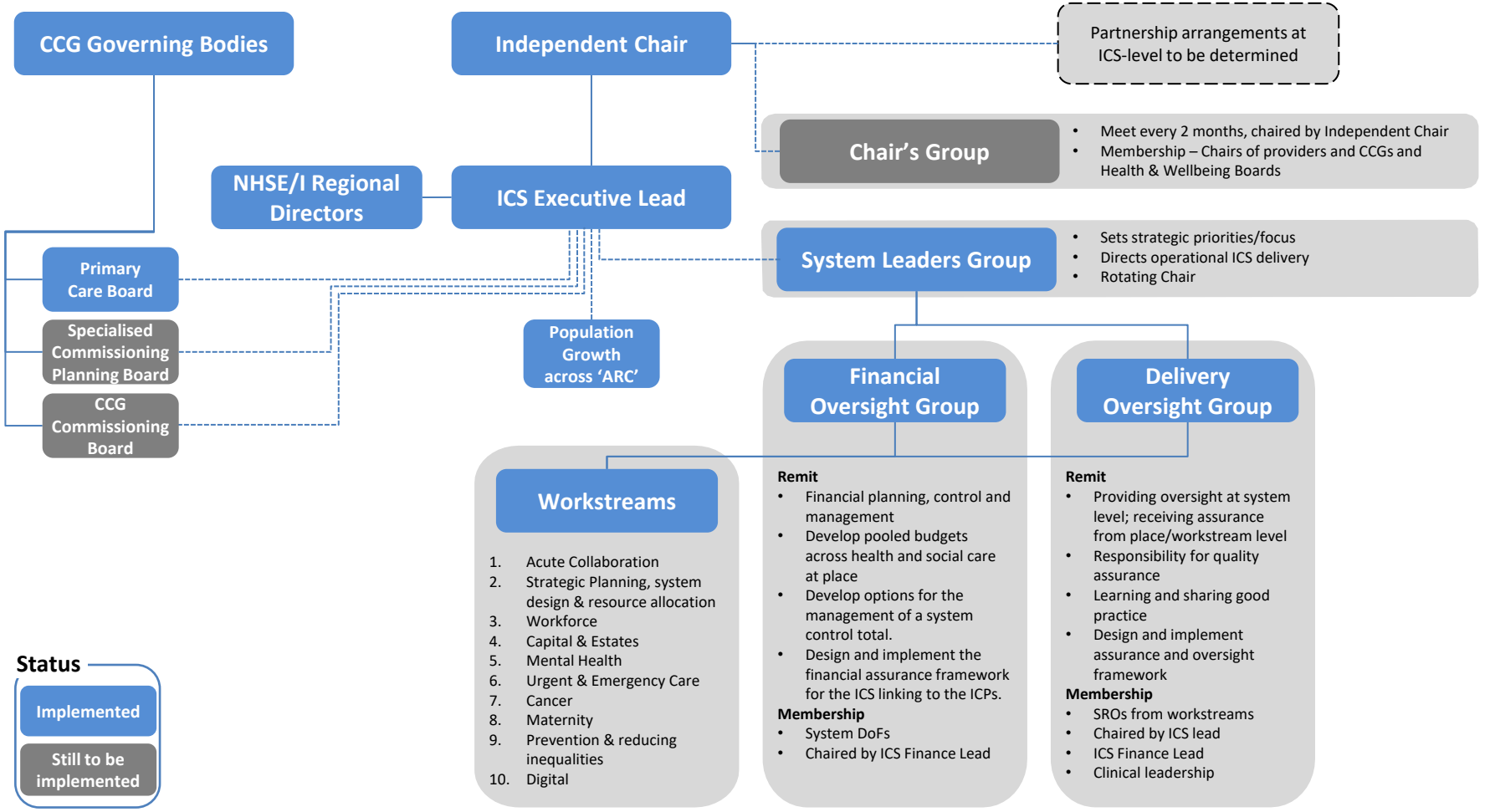
BOB ICS Governance arrangements

See illustration overleaf

BOB ICS is one of the four largest 'non metropolitan' ICSs in England – each health and care place (Buckinghamshire, Oxfordshire and Berkshire West) are larger than some ICSs elsewhere. As part of our journey to becoming a 3rd wave ICS we have strengthened our governance arrangements, including a Delivery Oversight Group that include county place leads. Our challenges drive the requirements for integration of health and social care across BOB ICS to improve care and quality, reduce variation and outcomes for our population and accelerate transformation across the system. While ICS meetings are not held in public, all participant organisations will exercise public accountability through their governance processes, bringing decisions and developing direction into the public-setting. The HealthWatch for each county is represented on the Delivery Oversight Group.

BOB ICS Governance

BOB Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System



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BOB ICS – vision and case for change

BOB Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Vision and case for change

2019/20 is an important transition year for the Buckinghamshire, Oxfordshire and Berkshire West (BOB) as it develops following the decision to become a 3rd wave ICS.

Following our Participation in the Supporting Aspiring Integrated Care System Programme and the publication of the NHS Long Term Plan, we have developed a BOB Priorities and Vision (right), including a set of collective priorities for ICS action for 2019/20.

This priorities and vision development will be closely aligned to governance changes as we have become BOB ICS, learning from the experience and adapting good practice from our two existing place-based ICSs.

BOB ICS Strategic priorities v9

ICS role	Description	Clarification and rationale
System design & delivery	Design approach to a problem at ICS level Deliver solution at ICS level	Population and economic growth; Acute collaboration; Strategic planning, system design & resource allocation
System design & place/org delivery	Design approach to a problem at ICS level but leave places/orgs to deliver	Digital; Workforce; Capital & estates
Set or confirm ambition and hold to account	Agree ICS ambition (or confirm ICS signs up to nationally set ambition) and hold places to account for/support delivery	Primary care, inc. Primary Care Networks (PCNs); Financial balance & efficiency; Mental health; Urgent & Emergency Care; Cancer; Maternity
Coordinate, share good practice, encourage collaboration	Bring places/ organisations together as a community of practice to share approaches and solutions	Research & Innovation; Children & young people; Personalised care; Prevention & reducing inequalities; Population health

ICS oversight running through all strategic priorities
Partnerships & Engagement, including patient and public involvement

Key

ICS workstream	ICS Financial Oversight Group	Place delivery supported by ICS-wide group	
ICS Exec Lead	Place infrastructure		

BOB ICS – outcomes and key activities

BOB Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Outcomes and key activities

We have agreed to adopt a collective framework for planning and prioritisation, based on a synthesis of the place and organisational strategies within BOB and the NHS Long Term Plan:

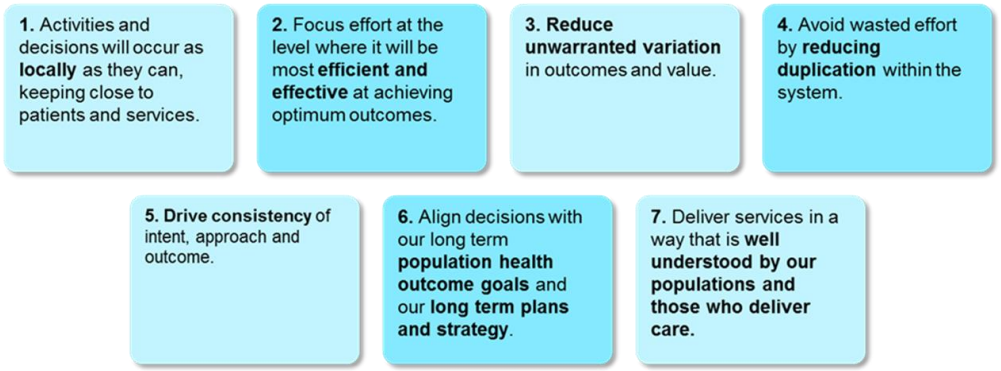
- Integrated Care, with particular work streams on primary care, urgent and emergency care and population health
- Prevention and Health Inequalities
- Care Quality & Outcomes, with particular work streams on Maternity, Mental Health, Cancer and Acute Care Collaboration
- Workforce
- Digital transformation – a shared priority including our Local Health and Care Record Exemplar programme but with work undertaken and coordinated at place-level within our ICS
- Efficiency and Productivity, including capital requirements
- Engagement and Partnerships

The BOB ICS has agreed a set of principles (set out below) for how we will operate that prioritises delivering care as close to the patient as possible but where there are outcome or efficiency benefits to operating at scale, we will do so. BOB ICS has a place-based focus, recognising that system working at a county level is a key driver of much of the transformation across the BOB footprint. These principles are to help us achieve the best possible outcomes and the best value for the population we serve.

In some cases, this will be at the ICS level; in other cases, it will be broader – for example, we have close links with Milton Keynes and Swindon in terms of patient flows; and work across ICSs/STPs through initiatives such as Pathology, Radiotherapy (linked to Care Quality Outcomes) and our Local Health and Care Records Exemplar. The ICS is not seeking to change its existing boundaries at this point, however, where there is benefit to patients, outcomes and sustainability the ICS will work with partners and stakeholders beyond its boundaries.

At present, integrated care and prevention are led at place-based level, including working in close partnership with Health and Wellbeing Boards across the BOB ICS. In these areas, we are still committed to learning from each other; and to working together across places, where this makes sense.

For example, we share very effective 111, 999 and integrated urgent and emergency care services through SCAS ad local out of hours partners and are continuing to work together to optimise how we offer more coordinated support for patients looking for same day urgent care through direct booking into a range of local and appropriate service options. Also this year Oxford University Hospitals NHS Foundation Trust (OUH) and Royal Berkshire NHS Foundation Trust (RBH) will be starting a joint dermatology outpatients clinic in Townlands Hospital, Henley and advertising joint posts for the Dermatology Service.



BOB ICS – partnerships, variations & inequalities

BOB Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Partnership governance

While our focus is on improving the health and care of our communities, we are also looking at how we can best organise ourselves to deliver on our ambitions. As part of this we are consulting on bringing together our three CCGs, in parallel to developing our response to the national Long Term Plan. Initially we are proposing appointing a single accountable officer across our existing CCGs, before bringing them together into a single commissioning organisation across the BOB footprint. This proposal is subject to consultation with our stakeholders and further details about this can be found here [link].

It is still at local, ICP level that systems will largely plan and commission care for their local populations, under joint system leadership bringing together NHS providers, commissioners and local authorities to work together in partnership to improve health and are in their areas. In addition to this place-based working, both our acute providers and mental health providers are exploring ways of further collaborating across BOB, while our primary care networks bring together primary and community provision.

Variations in care

We are activity looking for opportunities to work across the ICS on productivity and efficiency. Clinical support services – for example we collaborate across the ICS and more widely on pathology or genomics, which should result in both improved outcomes and/or greater efficiencies. We also work together across the ICS on capital prioritisation and planning. This priority area, alongside work to more effectively and collectively manage growing demand, will put us in a stronger position to deliver the ICS control total in the future.

Reducing health inequalities

Based on our principles, we expect to have a greater ICS-level (and beyond) focus on some aspects of care quality and outcomes and enablers such as workforce and efficiency. The BOB ICS population has generally better health outcomes than average – but we collectively face the challenges of increasing demand from an aging and expanding population in an area of economic and population growth.

The ICS will have a key role in understanding inequalities across the patch and working with place to ensure that sufficient progress is being made - offering shared best practice across the ISC and HWBBs , together with national and international learning.

The ICS therefore has a key role in bringing together system partners on elective care collaborations, identifying areas of capacity constraints and pressures where we may be able to provide each other with mutual assistance. Discussions are ongoing between our providers on a number of clinical specialties and this is a priority area for the ICS to support.

Population Health Management

Delivery of more joined up care for the populations collectively served BOB ICS and ICP is a golden thread of the plan. PHM will be integral to create a single source of truth, identify the priority opportunities to proactively target the right care for specific populations and shape the culture of the ICS and ICPs. To support this development BOB ISC will be participating in NHS England PHM Development Programme and builds on from the Berkshire West participation in the wave 1 programme . This will support BOB ICS and the ICPs to build our collective capability across the system, neighbourhood and networks to make informed data-driven decisions that enable teams to act together to make best use of collective resource to achieve practical and tangible improvements in the health and wellbeing of our communities.

Transformed 'out of hospital care' and fully integrated community based care – Developing our Primary Care Strategy

BOB Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

BOB Primary Care Strategy

The BOB primary care strategy – now part of the Long Term Plan - sets out the actions that will be taken across the three Integrated Care Partnerships to invest the new resource identified to deliver a transformed model of primary care. The outcomes for our patients will be:

- Improved access to care
- a stronger focus on population health and prevention;
- access to a wider range of practice staff, appropriate to clinical need;
- services delivered from modern buildings, co located with community and preventative services, hospital specialists and mental health care;
- more services delivered in the community, including in people's usual place of residence, that are currently delivered in hospital.
- primary care delivering key components of broader clinical pathways e.g. cancer, urgent care, and mental health.

Meeting new funding guarantee

To deliver this work, BOB ICS has an allocation for 19/20 of £10m. This will provide support, assurance, sustainability and investment in order to secure the services and new models of care needed. Further information on this allocation is provided below

Supporting development of PCNs

Much of this work is already in train, with Primary Care Networks already set up, with 100% coverage across the BOB ICS area. Clinical Directors have now all been appointed and are in the early stages of forming the development plans necessary to provide structure to the ambitions set out at a local level. As a system, a wide range of support mechanisms are in place to ensure these plans and structures are robust, sustainable, and in line with the Long Term Plan vision and principles, set out below.

Improving responsiveness to community health service crisis response

Looking beyond primary services themselves, there is an activity growth for A&E demand at 5%, and our hospitals have not met the 95% national target of A&E attendees being seen within 4 hours. There has been an increase in A&E and unplanned admissions and a decline in planned admissions and outpatients. Primary care could support this challenge and work to reduce pressure on hospital services, through a number of areas covered in the sections below, including:

- Implementation of five additional workforce roles through PCNS, providing opportunity to reduce pressure on emergency hospital services and better utilise the services available in primary care;
- Focus on digital enablers to support patient access to services;
- Alignment with Urgent and Emergency Care and wider ICS strategy towards a reduction in pressure in primary and emergency services;
- A focus on reducing inequalities across all areas in Primary Care and the use of Population Health Management to support a reduction in avoidable unplanned admission;
- Development of enhanced prevention activities to provide care to people at home, avoiding unnecessary attendance and admission and expediting a return home.

Creating a phased plan of specific service improvements

The Long term plan for delivery of the primary care vision rests in large part with getting the right workforce in place. The workforce section below sets out the plan over the next 5 years for recruitment of a wide range of professionals to support a multi disciplinary team within each community, lead by the PCN Clinical Directors.

Responsible for leading their network, Clinical Directors will:

- Provide overall leadership to their network
- Be responsible for providing strategic and clinical leadership to the PCN, developing and implementing strategic plans, leading and supporting quality and improvement and performance across many practices

Transformed 'out of hospital care' and fully integrated community based care

BOB Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

The table below shows the balance for the 5 years ahead, with detail for 19/20 beneath.

	Units	sign	2019/20	2020/21	2021/22	2022/23	2023/24
LTP Funding Allocation Summary							
Primary Medical and Community Services	£000s	+ve	**10,002**	**11,209**	**13,023**	**17,014**	**20,655**
a) Primary Care	£000s	+ve	10,002	10,387	11,104	11,420	11,247
b) Ageing Well	£000s	+ve	-	822	1,919	5,594	9,408

Primary Care LTP Funding	19/20
	£000s
Reception & Clerical Training	311
Online consultations	506
GP Retention	375
Practice resilience	236
Primary Care Networks	1,293
GP Access	6,377
Training Hubs	298
Fellowships Core Offer	266
Fellowships Aspiring Leaders	340
Total	10,002

Meeting the Funding Guarantee

The ICS is confident in the capability and capacity to deliver within the specified envelope for 19/20 and projects future activity for the next 5 years will be in line with allocations, with the addition of Ageing Well. Detail on future years will emerge following early development of the newly-formed Primary Care Networks, based on populations, need and delivery. This will be overseen throughout the period, as it is now, by both the Regional and the BOB ICS Primary Care Transformation Board, which holds representation from clinical leads as well as each locality. Further narrative on 19/20 funding spend is provided in the following pages setting out the Primary Care Vision of BOB ICS.

Transformed 'out of hospital care' and fully integrated community based care – Improving responsiveness to community health crisis response

BOB Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Our long-term vision for Primary Care

The following are a list of the key principles and components of a transformed primary care system:

1. Primary Care working at scale via Primary Care Networks will form the **operational building block** for wider service transformation and be a **core component of the BOB ICS**.
2. The **primary care workforce will expand to include a number of new roles** such as social prescribers, clinical pharmacists, medical assistants and physician associates and all staff will be up-skilled to work at the "top of their licence". This will support GPs to dedicate more time to the most complex patients who require their skills. This is likely to enable longer appointments for GPs to diagnose earlier and to manage complex conditions..
3. GPs will play a key role in leading the wider primary and community care team and will work with community providers to **develop community based extensive services** providing the medical oversight for their registered patients.
4. Every patient with an urgent care need will be able to **access same day primary care (in or out of hours).** This will not necessarily be face to face and with a GP, as new models of online access and advice, telephone consultations and other members of the primary care team meet this requirement. BOB has been running Improved Access/7 day working since October 2018 with £6.3m to commission delivery of improved access in BOB going forward. A national review of Access is currently underway, including improvements to ensure connectivity between systems & places.
5. All professionals involved in a patient's care will be able contribute to an **electronic shared care record** (role appropriate access). All providers will commit to sharing data for direct care and ensure their **systems are interoperable** with the shared care record. **Patients will be able to access their electronic shared care record** and use a range of online tools for managing aspects of their care.
6. **Technology will play an increasing role in providing alternatives to face to face appointments** and monitoring conditions, releasing the time of the primary care team for more complex activities. Work is already underway in each place, with contracts set up with technology providers, and an allocation of £506k to deliver technological solutions such as online consultations in 19/20. Further work is in development to ensure full coverage and smooth running between systems.
7. Services that can be delivered in the community will be provided within a neighbourhood or network, so that **patients can access care closer to where they live**, avoiding hospital attendance.
8. **Prevention will be a central feature** of primary and community care. PCNs will be supported with good analytics to understand the health of their population, segment and risk-stratify the population to provide targeted interventions to improve health outcomes. We will ask primary care networks to review the inequalities within their networks, this will be provided to them via the PCN profiles from Public Health England. This will be used to support reducing inequalities.
9. **Social prescribing and community empowerment** will be a key feature of primary care delivery to deliver more self-care. A key focus will be on building community capacity and capability. One example of delivery in this area is the rising demand for and development of Group Consultations in General Practice.
10. The **important interdependencies** between mental health, cancer and urgent and emergency care will be addressed through more integrated working within primary care networks.
11. . **Personalisation** - As one of the 7 new service specifications for the newly formed Primary Care Networks, Personalisation of care is key to the success of PCNs as they plan their future service delivery at network level from this year, with personalized care specifically to be phased in from April 2021.

Transformed 'out of hospital care' and fully integrated community based care – Improving responsiveness to community health crisis response

BOB Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Our long-term vision for Primary Care

Eye health - Patients will be able to access a consistent and integrated Primary Eye Care Service within PCNs across the BOB. The evidence-based schemes in terms of improved outcomes and cost effectiveness include the Glaucoma Referral Refinement, the Pre and Post Cataract Service, Minor Eye Conditions Service; Children's post screening eye test service, and the Low vision service.

Pharmacy services - Community pharmacy will act as a facilitator of personalised care and support for people with long-term conditions, maximising the pharmacy integration fund to work closely with and reduce the workload of General Practice. For example, in BOB the Cardio Vascular Disease Clinical Network is working with Community Pharmacy representatives on the collating of blood pressure readings data and identification of patients that need a GP referral. Community pharmacy will become a trusted first port of call for episodic healthcare advice and treatment; and will be integrated with NHS 111 and Community Pharmacy Consultation Service.
As community pharmacy focuses more on its clinical role of managing the minor illness aspects of urgent care; helping to improve safety, outcomes and value from medicines; and supporting patients to prevent ill health, it will need to have strong links with the Primary Care Networks (PCNs) Clinical Pharmacists, as well as with Social Prescribing Link Workers.

Oral health - Dental and oral health services will be integrated with PCNs working in neighbourhoods and emergency care systems ensuring patients' needs are met appropriately. Through these developments, practices will be able to transform and enhance their services - for example "Starting Well", increasing patient satisfaction and making maximum use of their staff skill mix. "Starting Well" is an NHS England/Improvement programme of dental practice-based initiatives which aims to reduce oral health inequalities and improve oral health in children under the age of five years.

Ageing Well

We will transform 'out-of-hospital care' and deliver fully integrated community-based care as part of our approach to Aging Well. We will develop a 2 hour crisis response (as set out in the Urgent Care Chapter) and work with primary care/PCN to implement an anticipatory care planning approach with patients and enhance care in care homes.

Across BOB our community teams will implement 'anticipatory care' for complex patients at risk of unwarranted health outcomes. We will build on assessment and planning approaches for people who live with moderate frailty as well as those people of all ages living with multiple co-morbidities. We will use the Electronic Frailty Index and clinical judgement to identify older people living with moderate frailty and their carers who are at risk of adverse health outcomes and provide them with tailored care which will be provided by community based integrated teams of GPs, Pharmacists, Nurses, and AHPs joined by social care and the voluntary sector. This work will support people to stay well and at home for as long as possible.

Our enhanced care programme for people living in care homes will build on the primary care DES. The intention is to help reduce avoidable emergency admissions, ambulance conveyances, and sub-optimal medication regimes. We will wrap care around the residential and nursing care, with enhanced primary care/specialist support in care homes, regular multi-disciplinary team resident reviews, including support from timely access to out of hours support and end of life care.

Transformed ‘out of hospital care’ and fully integrated community based care – PCN Development

BOB Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

PCN development

Primary Care Networks (PCNs), integrated multidisciplinary teams covering 30-50,000 registered populations, are the operational building blocks of the new care models. PCNs can also work together to operate at greater scale when required and they will be an important part of Integrated Care Systems. PCNs provide a route for a ground up transformation in health and care provision that engages front line staff in a new care model design. PCNs have the opportunity to redesign services in their neighbourhood. The new models that will emerge will provide better care for people with complex illnesses and multi-morbidity through longer GP appointments, integrated and extensive care to manage people in the community, and better acute “on the day” care 24 hours a day.

New PCN leaders will be supported in their set-up phase to achieve the above through the £340k funding provision for Fellowships for Aspiring Leaders in 19/20. Development of leaders and the wider PCN teams is already underway with a 13% proportion of the £1.2m PCN Development fund transferred to CCGs for immediate Clinical Director development support, and criteria being set by the BOB ICS Primary Care Transformation Board for how the rest will be drawn down by PCNs year on year.

Plans toward 2023/24

PCNs were established on 1 July 2019. Looking ahead and towards 2023/24, we aspire to PCNs having done **five things**:

- First, stabilised general practice, including the GP partnership model;
- Second, helped solve the capacity gap and improved skill-mix by growing the wider workforce by over 20,000 wholly additional staff as well as serving to help increase GP and nurse numbers;
- Third, become a proven platform for further local NHS investment;
- Fourth, dissolved the divide between primary and community care, with PCNs looking out to and integrating with community partners not just in to fellow practices;
- And fifth, systematically delivered new services to implement the Long Term Plan, including the seven new service specifications, and achieved clear, positive and quantified impacts for people, patients and the wider NHS.

BOB Population Health Management Development Programme

Population health management is one of the core functions underpinning the maturity of integrated care systems. Over the past 6 months, Berkshire West has participated in the wave 1 national Population Health Management (PHM) Development Programme to enable our system to make early, more rapid progress in the use of PHM techniques. Buckinghamshire and Oxfordshire will be in wave 2. Funding is being allocated within BOB through the PCN Development Fund – nominally £400k - in order to support the spread of this learning consistently across the ICS at the earliest opportunity – and subsequently nationally. Throughout the program, we have generated evidence of successful implementation of interventions targeted at specific groups of people and developed greater internal PHM capability in order to deliver the triple aim of improving health outcomes, improving patient experience and reducing per capita costs.

To sustain the momentum generated thus far in the PHM Development Programme and spread the learning across our system, we have worked with Optum and NHSE/I to upgrade our PHM Roadmap from August 2018 to progress our PHM capabilities. Specifically how we intend to continue to progress our maturity around our PHM infrastructure, intelligence, and interventions (across system, place, and PCN levels).

Transformed ‘out of hospital care’ and fully integrated community based care – PCN Development

BOB Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

What will it be like to a patient in the new model?

I feel that I am in control of my own health, with the support from a multi-professional team and I can receive appropriate community care where it is safe to do so. This includes the majority of diagnostic test and specialist appointments.

I can have access to my medical records and with the information I have been given through 111 online and the NHS App I can diagnose and manage most common illnesses myself.

I can also go to my local pharmacy for advice and support if I need more help.

I use technology to help me manage aspects of my care in my own home – the Drs and nurses who look after me can see my results and know when I need more help.

I now have access to a wider multidisciplinary team and so **I don’t always need to see a doctor** and I know what to do and who to call if I become unwell.

It is easier for me to access services; either online, telephone or even via email and I know I will be seen the same day if it’s urgent. When I need continuity of care, I can see my own doctor or nurse at an appropriate time and venue.

I am reassured now that if I ever get cancer and/or long I will have an improved chance of being diagnosed rapidly in the early stages of the disease rather than as an emergency.

I am reassured that I have access to a range of mental health care services, so I am able to seek support where required.

What will it be like to be a GP or Clinician in the new model?

My work is more fulfilling - being able to concentrate on diagnosing and managing complex illnesses, working with a skilled, multidisciplinary team, including hospital consultants. I feel in control of my workload through a reliable triage service.

I am part of a much wider team and have access to a range of services and options for patients, many of which are accessed by our social prescribers and provided by the community itself.

All the acute “on the day” work is managed so that patients get a rapid response from the appropriate team member

I am able to work in a range of locations with clinical access to IT systems and tools that I need, including in the patient’s home.

I have access to **dedicated time for education and development**.

I have a caseload of patients with complex needs for continuity of care and I am part of team of skilled staff that work well together.

I share relevant information with my colleagues through the electronic shared care record and use online tools to interact with my patients where appropriate.

I am content in my work and my family appreciate the fact they see more of me and I am not stressed.

The ICS has supported PCNs by aligning Community health, Mental Health, Social Care and Third Sector services around them. GPs lead the wider team and help decide where investment and support is required.

Transformed 'out of hospital care' and fully integrated community based care –Creating a phased plan of specific service improvements

BOB Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Vision for our Primary Care workforce

'Specialist and family doctors, community nurses, occupational therapists, physiotherapists, social workers, psychiatric nurses, psychiatrists and pharmacists - ***will offer treatment and care in teams who work together in local neighbourhoods around the needs of patients'***

Delivering our vision for workforce

To deliver this vision, the wider workforce in primary and community care will require support, supervision and development to ensure a safe and sustainable supply. The workforce supply will require more innovative routes in, supporting the principle of 'grow our own' and developing career frameworks.

Consideration will need to be made to ensure supply does not destabilise the wider health care system, with initiatives such as rotational models between organisations and services and widening the pipeline supply. Increased efforts to support pre-careers, work experience, apprenticeships and guaranteed learner placements, to encourage entry into primary and community care will be paramount.

As will using the skills of the retiring workforce in innovative ways to retain their skills and expertise within the system, to include education, mentoring, supervision and leadership roles. The wider workforce will need the skills to work in new ways and at advanced clinical practice, working in multidisciplinary primary and community teams around the needs of their population. This provides opportunity to maximise integrated and multi-professional training.

PCN workforce

The workforce in primary care will also transform in support of these new models of delivery with current staff being upskilled to take on new roles and new types of staff entering the primary care team such as First Contact Physiotherapists and Clinical Pharmacists. In addition, community health and social care and voluntary services will wrap around the PCNs and GPs will lead a new unified and integrated team. These changes will be further enabled by improved administration and better use of information and IT.

Training Hubs

Provision of this training will be supported through the development of Primary Care Training hubs. These are funded groups, with £298k allocated to their development and set up. The training hubs are designed to be:

- The 'go to' place for primary & community care training and development for BOB ICS
- Delivery arm for HEE for primary and community care (HEE functions in the local system)
- Delivery vehicle for BOB primary care strategy workforce programmes
- Support PCNs in embedding new roles and new ways of working (workforce transformation)
- Support primary and community

Targeted training & development for roles such as Social Prescribers and GP Assistants to support this model going forward is to be supported through the £311k funding for Reception & Clerical training 19/20. A number of social prescribers have been trained and are delivering workflow optimization. This will also include roles in delivering Group Consultations as an effective and efficient new model of care. 'New to Practice' fellowships from the Fellowships Core Offer fund will support the set up of new roles within general practice in upskilling and support for non-GPs

Transformed 'out of hospital care' and fully integrated community based care –Creating a phased plan of specific service improvements

BOB Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

GP Workforce Trajectories 2019/20

Where we are now:		
GP's (Exc Reg, Retainers and Locums) *	HC	1,154
	FTE	883
GP's aged >55 *	HC	235
	FTE	* 180
GP Reg	HC	88
	FTE	81
Locums	HC	65
Other e.g. GPs not accounted for	HC	14
	FTE	6

Future 2020:		
GP's (Exc Reg, Retainers and Locums) *	HC	1322
	FTE	1011.5
Current		
Specialists doctors working in Primary care:	HC	
	FTE	

Gap:	
HC	168
FTE	128.5

Workforce Planning Tool

A new tool to support workforce planning is currently in development, due to launch at the end of 2019. This IT platform is designed to support workforce planning for GP Practices, PCNs, CCGs and the ICS. The idea of the tool is to address the capacity gap shown above. One way of managing the gap between capacity and demand is to use other healthcare professionals to take on some of the work undertaken by GPs and Practice Nurses. Functions of the tool include:

- **The Age and Sessions RAG Rating Tool** has been designed to help with forward workforce planning, two years and five years ahead. It will help highlight impending retirements and the consequent shortfalls in sessions staffed per week.
- **The Skills Matrix** has been designed to show which professionals can undertake a selection of functions in general practice. Instead of trying to fit the staff to the role, use this tool to identify which staff can perform all the functions you require.
- **The Workforce Tool** has been designed to determine the time required and cost of each type of non-medical workforce member required to undertake consultations in place of a GP.
- **The PCN Tool** has been designed to show the aggregated workforce data for a set of practices. The tool will highlight the aggregated number of GP consultations as well as the estimated savings

GP Retention

The BOB ICS GP retention programme seeks to support GPs working across BOB. The programme is delivered through our primary and community care training hubs and is divided into 3 workstreams. Each project workstream provides its own individual focus and combine to provide a cohesive range of services to support GP Retention across BOB. The programme will also complement and refer to other National and Local initiatives aimed at supporting the GP workforce. The projects are: 1) Locum chambers; 2) Flexible career programme; and 3) Mentorship & Support. The current GP Retention funds have been allocated with space for planned expansion based on evidence of current demand.

Transformed 'out of hospital care' and fully integrated community based care –Creating a phased plan of specific service improvements

BOB Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Wider Workforce

The Primary Care Network (PCN) Directed Enhanced Service (DES) sets out funding for Additional Workforce Roles to be employed across a PCN. Based on an average PCN of 50k registered patients, the PCN would be entitled to the number of roles shown the table below (Additional workforce for an average 50k PCN – blue table). The second table (green) shows the aggregated BOB numbers. Role numbers are not set, as long as the PCN stays within its Workforce envelope these figures can be altered according to need.

Average 50k PCN in BOB					
	19/20	20/21	21/22	22/23	23/24
Clinical Pharmacist	1	1.8	2.6	3.4	4.2
Social Prescriber	1	1.8	2.6	3.4	4.2
First Contact Physio		1	1.8	2.6	3.4
Physicians Associates		1	1.8	2.6	3.4
Community Paramedics			1	1.8	2.6

BOB ICS- 45 PCNs year 1 then average 36 PCNs at 50k average					
	19/20	20/21	21/22	22/23	23/24
Clinical Pharmacist	45	81	117	153	189
Social Prescriber	45	81	117	153	189
First Contact Physio		45	81	117	153
Physicians Associates		45	81	117	153
Community Paramedics			45	81	117

Additional roles

- Clinical Pharmacists Programme - A dedicated clinical pharmacy team undertaking structured medication reviews, improving medicine optimisation and safety, supporting care homes, as well as running practice clinics.
- Mental Health Therapists - major expansion to the community health workforce and integration between physical and mental health (building on the co-location of IAPT workers)
- Physician Associates - works directly under the supervision of a doctor as part of the medical team (usually a generalist)
- General Practice Nurses - continued programmes of work to support the National GPN 10 point plan
- Physiotherapists - Advanced practice physiotherapists to work as MSK first contact practitioners, working independently and do not require supervision (releasing GP workload)
- Paramedics - working autonomously in communities, using enhanced clinical assessment and treatment skills, to provide first point of contact for patients
- Social prescribing link workers - will have a key role in enabling patient choice, peronsalised care planning, community-based support, and supporting self-management, personal health budgets and integrated budgets

Transformed 'out of hospital care' and fully integrated community based care –Creating a phased plan of specific service improvements

BOB Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

BOB ICS Wide Primary Care Estates Strategy

In January 2019, initial discussions were held with primary care leads to start drafting an ICS-wide primary care estates strategy, recognising that each place (Berkshire West, Oxfordshire and Buckinghamshire) were at different stages in understanding their existing primary care estate and setting priorities and investment plans for the future.

With the advent of Primary Care Networks being the building blocks of all future service delivery, and the launch of a primary care strategy across BOB by the Autumn of 2019, it was agreed that a working group tasked with drafting the primary care estate strategy would be convened post September 2019

The processes involved in refreshing existing place strategies and forming a coherent one-system BOB ICS wide strategy will include:

- *Provision of a 6 facet survey for the entire PC estate*
- *Liaison with Planning departments of local authority partners to assess population growth through new housing*
- *Gravity mapping of projected growth to establish most likely GP destination of choice for new population*
- *Reassessment and support development of existing pipeline schemes*

Digitally-enabled Primary Care

The BOB Digital Workstream will ensure the development and effective use of ICT infrastructure across the ICS to improve joined-up working, information access and sharing. We will make improvements to our digital infrastructures and the provision of digital tools to reduce burden on our workforce to better support staff in their roles.

NHS-led provider collaboratives will be developed locally and should ensure that digital plans use the reasonable adjustment 'digital flag' in the patient record or, where this is not available, use the Summary Care Record as an alternative. (autism and LD)

Moving to paperless is a critical deliverable to improve access to real time data, improve efficiency and deliver clinical benefits. All BOB partners are committed to delivering this.

Further information on all digital aspects of Primary and Community Care delivery within BOB ICS can be found within the Digital chapter.

Digital will be integral to achieving a number of Primary Care ambitions, in particular improved patient experiences:

- *'I can have access to my medical records and with the information I have been given through 111 online and the NHS App I can diagnose and manage most common illnesses myself'*
- *'I use technology to help me manage aspects of my care in my own home – the Drs and nurses who look after me can see my results and know when I need more help'*
- *'It is easier for me to access services; either online, telephone or even via email and I know I will be seen the same day if it's urgent. When I need continuity of care, I can see my own doctor or nurse at an appropriate time and venue'*

And improved clinician experiences:

- *'I am able to work in a range of locations with clinical access to IT systems and tools that I need, including in the patient's home.*
- *'I share relevant information with my colleagues through the electronic shared care record and use online tools to interact with my patients where appropriate'*

Reducing pressure on emergency hospital services (EHS)

BOB Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Long Term Plan commitments

People experiencing an urgent or emergency health issue want to be confident that they will be assessed quickly and reliably, managed in a location that is convenient to them and cared for by a clinician that can meet their need, giving clear advice to allow self-care where appropriate or ensure they can return home swiftly and safely following treatment.

We will establish primary care as the centre of our same day response to patients, providing expert assessment and treatment closer to home, avoiding acute hospital care unless absolutely clinically necessary, ensuring patients are managed in their homes wherever possible and appropriate. Across Buckinghamshire, Oxfordshire and Berkshire West (BOB), we anticipate that community-based same day care services will be delivered in partnership with Primary Care Networks (PCNs), groups of practices that coordinate care to their registered patients and those that work in or visit the locality. Wherever clinically appropriate we want to support patients to access *their own practice* for care.

For patients with minor injuries or illness that occurs when practices are unavailable, we will continue to make access straightforward through 111 and 111 Online. These services operate jointly with community-based services to deliver Integrated Urgent Care (IUC), providing people with expert advice and where necessary, a confirmed appointment in a local service that can meet their needs. This will include Urgent Treatment Centres (UTCs) 7 days a week and, when a patient's own practice is not available, Out of Hours primary care overnight and at weekends.

UTCs are established in Buckinghamshire and Berkshire West. In Oxfordshire, walk-in alternative community services aligned to primary care are being developed from existing sites. These sites provide seamless integration with 111 and primary care in and out of hours to offer patients comprehensive, community based care.

Where patients need an urgent response in their own home we will develop a 2 hour crisis response that delivers assessment, and short-term interventions for up to 48 hours and home based reablement within 48 hours where indicated, in line with the national *Ageing Well* programme. This 2 hour response will be accessed via 111 and/or primary care and be delivered by a multi-disciplinary team. This response will deliver person-centred assessment and care that builds on the patient's own strengths and resources. We will explore models of therapist/paramedic in a car, geriatrician support to community decision-making and 24/7 social care integration, as well as local Single Points of Access for targeted populations.

It will take a multi-disciplinary approach to managing health and other needs that helps people stay at home, or make a planned move to another setting and avoids crisis use of emergency care services This approach will typically work with older people living with frailty in the community and will be developed alongside PCNs. It is our intention to bid for accelerator funding to develop and implement both BOB-wide access to 2-hour response and local operational models of delivery.

Patients requiring additional diagnostic testing, or more specialised assessment and care will be supported both in the community and acute hospitals, with the focus on returning them home with the support they need that same day. This ambulatory care is focused on rapid multi-disciplinary assessment of a patient's needs, with senior clinical decision making that can be provided safely without the patient requiring an overnight stay.

For people facing a serious, perhaps life-threatening illness or injury, we will ensure that emergency services are responsive and timely, providing expert assessment and treatment at the beginning of a pathway that offers continuity of care and coordination with the patient and their family to manage any related future needs. High acuity patients that require a stay in hospital will be provided with health and social care input from the point of admission, setting clear expectations regarding recovery and return to their usual home where clinically possible.

Reducing pressure on EHS - introduction

BOB Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

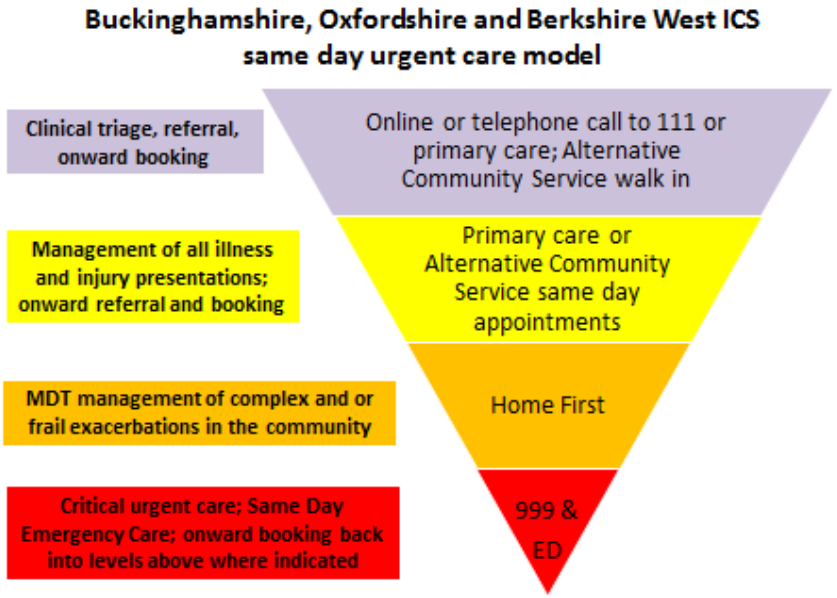
Long Term Plan priorities

Integrated Urgent Care - NHS 111 will increasingly become the single point of access to urgent care services, including primary care. The number and types of clinicians available to give advice to callers will be increased, such as midwives, paediatric and end of life specialists, as will the numbers of services that patients can be directed to, including rapid community response and reablement. If a patient or their carer needs to see a healthcare professional face to face, NHS 111 will be able to book them into an appointment.

Same day urgent care closer to home - Capacity and responsiveness in community health crisis response services for both physical and mental health will be increased to provide support to those that need it the most. Flexible teams will work across primary and community care providing recovery, reablement and rehabilitation support to individuals keeping them well, preventing crisis and supporting recovery after a hospital stay. We will strengthen working with colleagues in these services to improve our response to urgent same day access and management of illness.

Bed based care - We will work with our community services and ambulance provider to ensure that only patients who really need hospital based care come into hospital. New pathways of care will ensure that more patients will be treated without an overnight stay and for those that need admission length of stay will be minimised.

Home First - Health and social care are working in a more integrated way to ensure that, following a hospital stay, patients can return to their own home with any support that they require. This will include the use of voluntary sector services to help people maintain independence and wellbeing.



We will also work with patients, their carers and families to encourage these behaviours:

- *I will take responsibility for managing my and my family's health*
- *I will call 111 or access my own practice if I need urgent health advice but it is not a life threatening emergency*
- *I will accept the advice given and take the recommended course of action*
- *I will own and manage my personal health information allowing access to ensure healthcare professionals can give the best care possible*
- *I will educate myself and my family about local service provision*

Reducing pressure on EHS - where are we now (1)

BOB Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Integrated Urgent Care

In 2018-19, the Thames Valley IUC service responded to 606,040 calls, approximately 50,500 a month. Of these, 30% are managed on the phone, 45% are referred to the community for a face to face assessment while 12% of calls result in a transfer to 999 and 6% are recommended to attend ED. The IUC service is meeting its required targets for the rate of clinical contact (50% of all calls). There is ongoing challenge in the recruitment and retaining of clinicians within IUC which will be a focus for the future.

Primary care and Urgent Treatment Centres

Patients with minor illness or a new injury are also able to walk in to a range of sites – in Buckinghamshire an Urgent Treatment Centre (UTC) is available 24/7 at Wycombe Hospital, offering care by GPs and nurses, with a second UTC providing care for the largely rural population around Newbury in Berkshire West, available 12 hours a day. In Oxfordshire we will be developing alternative community services aligned to primary care from existing sites. We are still considering how patients in central Reading can be cared for within existing walk-in facilities.

Supporting patients to return home

The SAFER discharge bundle, which provides best clinical practice and reduces unnecessary delays, has been implemented in all acute sites, with the principles being adopted across a number of community wards, in addition to implementation of a discharge patient tracking list.

Within all acute sites, therapy and social work teams are integrated at the beginning of the hospital pathway; In Buckinghamshire the REACT service (Rapid Enablement Adult Community Healthcare Team) is in place 7 days a week and future focus will be on the development of integrated admission avoidance services.

Improving care pathways and adding value to patients' lives

The Integrated Care System (ICS) is focusing on how to better support patients with frequent, potentially clinically inappropriate contact with health and social care services, often in high acuity settings such as the Emergency Department or Emergency Ambulance service. These patients, known as 'High Intensity Users' (HIUs), reach out in an unplanned manner to health and social care with significantly higher frequency than other patients, with such contact reflecting a range of concerns, including physical, mental health and societal drivers.

We have developed Population Health Management (PHM) which aims to establish a greater understanding of the BOB population's current and future health needs; this work focusses in particular on patients aged 65 and over with high numbers of admissions to hospital, aiming to provide intensive support for the most high risk patients (1-5% of the population) and proactive management of rising risk patients (up to 35% of the population) to avoid unnecessary higher acuity, higher cost care.

The development of support to High Intensity Users will take account of the cohort that is shared within the focus of PHM, but recognises that there will be a significant population under the age of 65 who require increased or improved coordination of care and support.

We will seek to align the mental health crisis and urgent care pathways to ensure that patients have their health needs met in the most appropriate setting and improve the efficiency of our model. We will develop models such as Street Triage and SCAS triage for people in mental health crisis and assure that our acute sites meet the Core 24 standard for psychiatric liaison.

Reducing pressure on EHS - where are we now (2)

BOB Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Emergency Ambulance – South Central Ambulance Service (SCAS)

At the end of 2018-19, emergency ambulance activity had grown by 5.2% compared to the previous year. In BOB, Category 1 performance in 7 minutes for life threatening cases was achieved (an average of 6 minutes and 58 seconds response) and Category 1 performance in 15 minutes was also achieved. For Category 2 (serious conditions which require urgent attention), the average performance against the 18 minute target was 16m7s, and the 40 minute 90% target was met.

Approximately 6.9% of calls to 999 are managed over the phone, with a further c. 33% attended by crews who safely manage the patient in the community. On average, 54.9% of calls resulted in conveyance to an Emergency Department. SCAS is in the top 2 Ambulance Services for avoiding conveyance to EDs and Oxfordshire excels at providing conveyance opportunities to non-ED endpoints. Therefore, there are more limited gains to be made than in other areas of the country but the Urgent Care Pathways programme in SCAS is focused on further improving this performance.

Ensuring 100% ambulance handover occurs within 30 minutes is a challenge across the ICS due to the increasing numbers of high acuity patients requiring conveyance to the ED and rising pressure on majors departments. However, the ICS acute hospitals perform reasonably well as a group compared to national averages. The 'Rapid Assessment and Treatment' process at Stoke Mandeville has drastically reduced handover times, with Stoke Mandeville hospital now being a local exemplar for handover efficiency.

SCAS is one of three Global Digital Exemplar Ambulance Trusts creating exemplar projects in Ambulance services. SCAS is leading in the areas of advanced digital telephony, using ambulances as a technical hub, pre-arrival messaging into acute hospitals, resource planning and intelligent forecasting and finally, automation to improve people processes and education.

Managing patients in a hospital setting

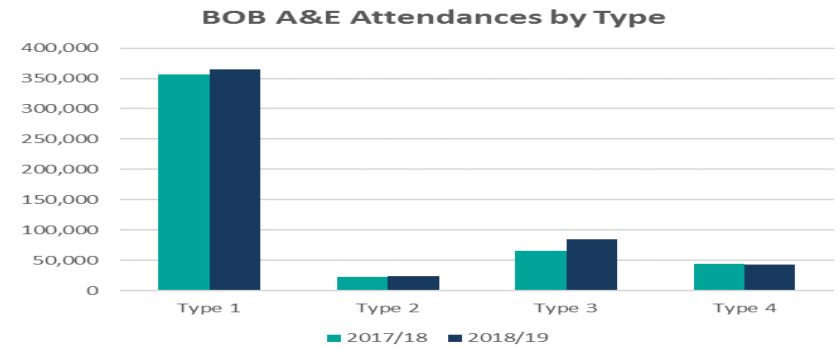
Across the ICS, acute frailty services are delivered to a minimum 70 hours a week, with patients receiving assessment within 30 minutes of arrival. In Berkshire West, this is delivered via an Occupational Therapist-led service based in the Emergency Department, while in Buckinghamshire, care is provided via REACT (Rapid Enablement Adult Community Healthcare Team) working 12 hours a day 7 days a week plus 10 hours a week Emergency Care Geriatrician (2 hours a day Monday to Friday) provision. In Oxfordshire frailty services are in place over 70 hours at the John Radcliffe Hospital, with clear plans to expand provision at the Horton Hospital beyond 70 hours.

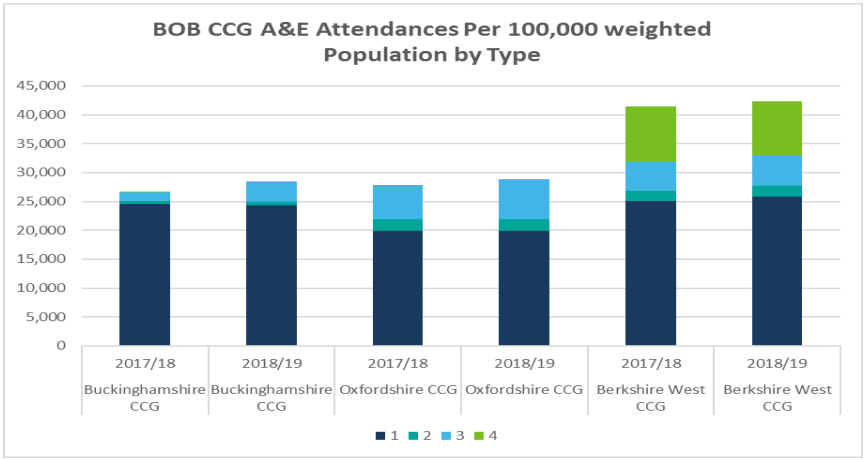
Across BOB, all acute trusts delivery Same Day Emergency Care (SDEC) 12 hours every day. In Oxfordshire and Buckinghamshire, more than 30% of non-elective admissions are managed via SDEC currently; in Berkshire West, more than 30% of non-elective admissions are managed in this way but the Trust is looking to further improve its management of medical patients and is participating in the SDEC accelerator programme.

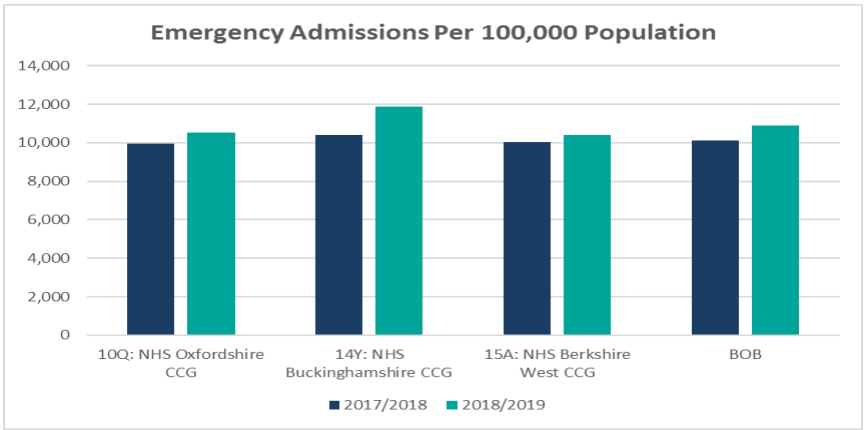
This strategy of rapidly assessing and managing patients in an ambulatory care setting improves their experience, being safely returned home without an unnecessary overnight stay.

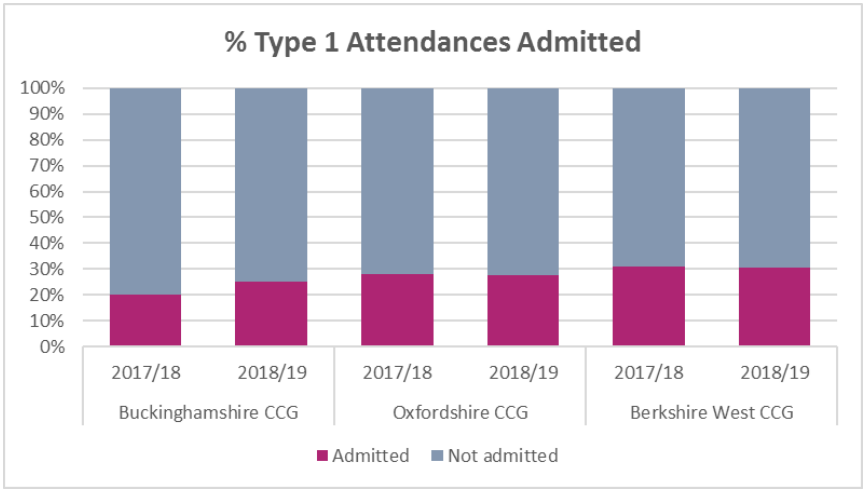
Reducing pressure on EHS - Activity & Performance

BOB Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System





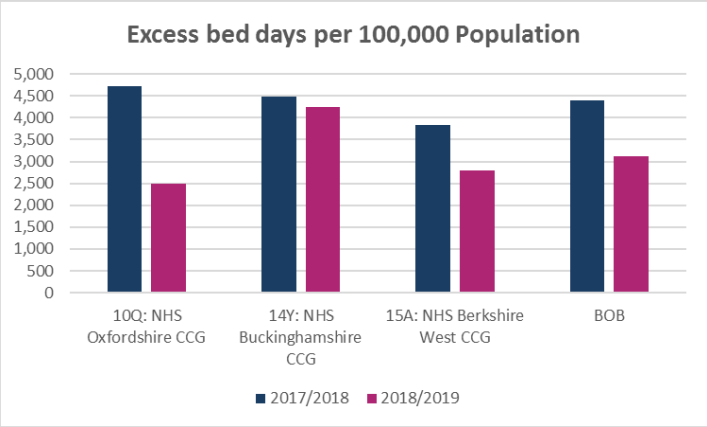


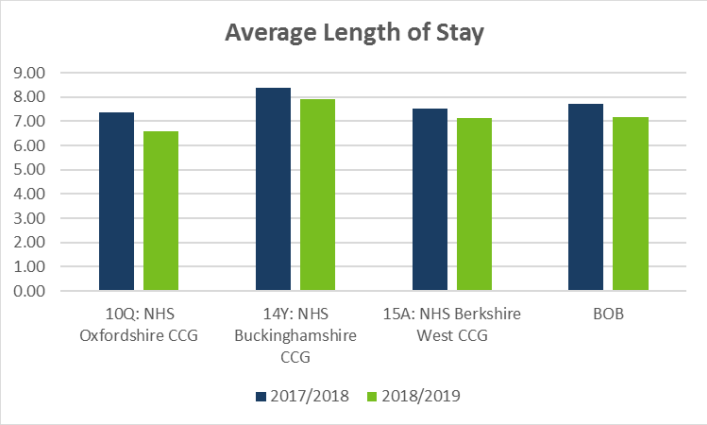


- Emergency Department (Type 1), specialist ED such as eye casualty (Type 2) and Minor Injury Unit / Urgent Care Centre attendances (Type 3) increased from 17-18 to 18-19. Attendances across the ICS rose by 6% overall between 2017-18 and 2018-19.
- Although Type 3 attendances make up about 15% of the total same day activity across BOB, they have increased by 28% between 2017-18 and 2018-10 – patients have increased their use of care in the community but numbers attending Emergency Departments have also risen.
- Berkshire West has the highest volume of ED Attendances per 100,000 population; Buckinghamshire has the highest volume of emergency admissions per 100,000 population
- About 27% of Type 1 ED Attendances across BOB result in an admission
- Emergency admissions for BOB as a whole increased by 10% between 2017-18 and 2018-19

Reducing pressure on EHS - Activity & Performance

BOB Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System





- The volume of excess bed days per 100,000 population decreased by 29% in 2018-19
- Average length of stay reduced by 7% across the ICS in 2018-19

Acute NHS Delayed Transfers of Care by Provider Trust 2018-19

Provider Trust	Acute	Non-Acute	Grand Total
FRIMLEY HEALTH NHS FOUNDATION TRUST	527.8	43.7	571.5
OXFORD UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	411.7	0.0	411.7
BUCKINGHAMSHIRE HEALTHCARE NHS TRUST	166.4	196.6	363.0
HAMPSHIRE HOSPITALS NHS FOUNDATION TRUST	312.3	0.0	312.3
MILTON KEYNES UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	241.7	0.0	241.7
ROYAL BERKSHIRE NHS FOUNDATION TRUST	199.4	0.0	199.4
OXFORD HEALTH NHS FOUNDATION TRUST	0.0	177.8	177.8
BERKSHIRE HEALTHCARE NHS FOUNDATION TRUST	0.0	117.2	117.2

Space for Ambulance activity

Reducing pressure on EHS – what we will do (1)

BOB Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Integrated Urgent Care

1. Increase the number of appointments within GP practices available for 111 to directly book, supporting patients by offering them a clear next step in their care pathway.
2. Expand the Clinical Assessment Service (the CAS is the collective name for the multi-disciplinary team of clinicians that work within 111) to offer additional clinical capability including specialists for mental health, paediatrics and end of life care.
3. Ensure that Integrated Urgent Care has robust links to community based services to allow for rapid 2-hour response and access to reablement, both for patients at risk of conveyance to or following discharge from hospital.
4. Determine how the CAS can support Primary Care Networks as they mature, offering additional ways for practices to manage same day demand and considering how to support delivery of the 2-hour response we aim to implement in line with *Ageing Well.*
5. Implement MiDOS, providing improved support to crews managing patients in the community and avoiding clinically unnecessary conveyance to Emergency Departments, in addition to providing information to patients about their local services.
6. Develop one Clinical Assessment Service to work across 111 and 999 to support integration across the two services.
7. Provide the clinical expertise within the CAS to a wider range of frontline clinical staff, supporting the ethos of 'no decision in isolation' and enabling rapid access to specialist advice when a clinician is face to face with a patient.
8. Review the potential for closer alignment of Out of Hours primary care across Buckinghamshire, Oxfordshire and Berkshire West.

Primary care and Urgent Treatment Centres

1. We will develop pathways where the default access point for same day urgent care is always a phone call from the patient to 111 or primary care and where we can assess and direct patients across the range of physical and mental health presentations, or offer alternative routes for support.
2. All minor injury and minor illness services will have the capability and capacity to book patients onward into appropriate services, including escalation to acute physical and/or mental health care where clinically required.
3. Scope further development of Urgent Treatment Centres and ensure robust integration between Primary Care Networks, UTCs and Integrated Urgent Care.
4. Channel same day demand into available PCN capacity where clinically appropriate, with a strategy of booked appointments via 111 and the patient's local PCN over unplanned walk-in to urgent care facilities. We will work with primary care to provide direct connectivity and support for local minor illness care, widening options for patients through a 'phone before you go' model.
5. Channel clinically inappropriate activity away from Emergency Departments to relevant community based services.

Managing patients in a hospital setting

1. Increase engagement of health, social care and the voluntary sector / community assets at the beginning of patient pathways, ensuring patients and their carers have a clear understanding of discharge, including when and how they will return home.
2. Ensure that the patient's mental health and social circumstances are assessed and addressed as part of care and discharge plans.
3. Improve ambulance handover through the use of rapid assessment and treatment processes.
4. Continue to provide rapid assessment and management in frailty and ambulatory care settings, to support safe and effective return home the same day, where clinically appropriate.

Reducing pressure on EHS – what we will do (2)

BOB Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Emergency Ambulance Services

1. Provide proactive care, using technology to monitor patients and make welfare calls to those at risk of deterioration.
2. Improve survival rates and management of patients at risk of cardiac events, stroke, trauma and those with serious exacerbations of their long term condition, with direct access to clinically appropriate services and expert advice.
3. Improve appropriate management of patients with mental health needs at a point of crisis and patients with learning disabilities.
4. Continue to provide proactive and rapid response of patients at risk of falling or who have fallen.
5. Improve support to palliative care patients in the community and their carers, to avoid unnecessary conveyance at the end of life.
6. Ensure there is one "employer of choice" for every current and aspiring paramedic living in South Central England, which every partner in the BOB ICS can turn to when seeking to utilise the paramedic workforce and where the oversight of the paramedic workforce is maintained.
7. We will support any of our partner organisations to continue with their pioneering work in digital transformation and digital enablement.
8. We will create a 'Total Transport Solution' for all non-emergency Health and Social Care Transport and Logistics Operations across Buckinghamshire, Oxfordshire and Berkshire West.

Supporting patients to return home

1. Maintain multi-disciplinary management of delayed patients and those with a long length of stay, including regular Executive focus and support to help patients home safely.
2. Further develop 7 day working, improving discharge levels at weekends to reduce the potential for patients to remain in hospital with a long length of stay.
3. We will seek to become an Ageing Well accelerator site, acting as a regional and national champion for the development of Urgent Community Response and Anticipatory Care.
4. Improve coordination with the third sector to provide additional non-medical support to patients and their families in hospital and at home.
5. Develop a coordinated response to the domiciliary care market across BOB to decrease differential approaches to pricing, acceptance criteria and staffing.

Improving care pathways and adding value to patient's lives

1. Ensure that patients with frequent and unplanned contact with high acuity services are managed in a multi-disciplinary manner, with regular review of their needs and coordinated *personalised* support to understand what drives their behaviours and address relevant factors in their lifestyle or conditions.
2. Have schemes in place to support High Intensity Users, coordinated with a Population Health Management approach that provides early identification and support to patients with long term conditions, frequent unplanned use of services or chaotic lifestyles.
3. Deliver the new urgent & emergency clinical standards for care, including stroke, trauma, sepsis and heart attack. We will ensure that patients requiring critical care receive assessment within 15 minutes and treatment in an hour, providing responsive, safe care across all pathways.

Reducing pressure on EHS - Financial Balance

BOB Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Delivering a financial balance for the service across place & system

The challenge for Urgent & Emergency Care services in terms of supporting financial balance will be managing the growth in activity, year on year.

The focus will be on addressing this rising demand rather than delivering substantial savings by reducing activity below baseline levels. There will be opportunities to channel some demand to lower acuity (and lower cost) settings through digital and telephone assessment within 111 or primary care, with a corresponding reduction in patients with minor illness or injury attending Emergency Departments. 111 will also provide increased opportunity for patients to self-care, where clinically appropriate, reducing unnecessary contact with services.

In ambulance services we will increase rates of Hear & Treat (patients managed safely by phone) and See & Treat (patients managed at the site of their call), with a decrease in the rates of See, Treat & Convey. Where conveyance is required, we will increase the number of patients conveyed to community settings rather than default to the Emergency Department.

Through improved discharge processes, including reductions in Delayed Transfers of Care and Long Lengths of Stay, we will reduce the number of excess bed days across the system, in addition to increasing provision of frailty services and Same Day Emergency Care to improve the ability of the system to support patients home safely and reduce clinically unnecessary stays in an acute setting.

Key opportunities that may require additional resource & funding

Area of focus	Long Term Plan ambition	Resource required
Integrated Urgent Care	- Expansion of IUC to include referral to community response and reablement	
Urgent Treatment Centres	- Development of UTC in Aylesbury - Development of Oxfordshire walk-in alternative community services aligned to primary care	£5 million capital & c. £1m running costs
Ambulance Patient Transport	- 'Total Transport Solution' for non-emergency Health & Social Care Transport and Logistics	
Hospital	- Implementing new clinical standards for care - Emergency Department estates configuration in Berkshire West & Buckinghamshire - Increasing effectiveness of 7 day working and Frailty pathways, reducing Long Length of Stay and Delayed Transfers of Care	Buckinghamshire estates need to be reviewed in 19/20 c. £200k Buckinghamshire c. £1.5m Oxfordshire
Adding value to patient's lives	Implement Population Health Management strategy and support to High Intensity Users	c. £112k in Oxfordshire
Total		

Reducing pressure on EHS – key risks to delivery

BOB Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Urgent & Emergency Care services face **rising demand annually**; as our services improve their ability to manage patients effectively in the community for longer, those arriving in an acute setting are increasingly of high acuity and require more significant intervention. This increasing demand, year on year, is the most significant challenge to Urgent & Emergency Care services and will be managed via increased improved coordination between community, acute and emergency services.

The **maturation of Primary Care Networks will be key**, with an incentivisation scheme to reduce non-elective attendances due to be published by NHS England and NHS Improvement (NHSEI). Networks will have to work closely with SCAS to develop robust alternatives to conveyance and support crews on scene with rapid advice and, if required, assessment of patients. Networks will also require close collaboration with rapid community response and social care services, to safely maintain patients in their homes.

While the intention of the ICS is to encourage patients to seek same day care through their Primary Care Network or 111, there is a **significant cohort of patients that choose to access care by walking in, either due to lack of access elsewhere, perceptions of convenience, cultural preferences or logistical issues such as proximity of services and language issues.** There are also significant challenges in identifying patients in the community that require assessment in hospital early enough in the day to avoid a default overnight stay, as their pathway often involves a request for GP home visit late morning with this being undertaken in the early afternoon and the patient requiring subsequent transport to hospital, assessment and treatment which may take place in the evening. BOB will scope how to move this demand profile earlier in the day through earlier assessment in the community and how to encourage greater use of 111 over walking in unplanned, to seek care.

BOB has made significant improvements to the management of Delayed Transfers of Care and patients with a long length of stay. **There remain challenges however in domiciliary care capacity (including recruitment and retention of staff) and the ability of services to accept new patients at the weekend or late evening**, which means that acute and community hospitals may not maintain robust throughput. As identified above, BOB intends to develop a comprehensive approach to the domiciliary care market including pricing, acceptance criteria and staffing, to ensure that when a patient is medically fit for discharge they can be supported home effectively.

Voluntary and third sector agencies are well engaged with the three A&E Delivery Boards and are playing an increasingly important role in supporting patients to settle at home, through befriending services or welfare checks; we will continue to explore how such support can enhance discharge and how personalised care planning may provide more sustainable outcomes for patients.

There are **significant workforce gaps within urgent & emergency care**; the GP and district nursing workforce that are vital in maintaining patients safely in the community have substantial recruitment gaps. The paramedic workforce is highly sought after by practices and there are challenges for the Ambulance Service both in recruitment of sufficient numbers but also in their retention; as identified above, greater coordination between SCAS and other partners to manage this workforce is planned.

Some Emergency Department facilities are challenged in their physical capacity to manage increasing levels of demand. While the use of ambulatory care services has supported more efficient use of space within acute settings, we will review existing estates and in the case of Oxfordshire, plans are in place to expand both the John Radcliffe and Horton Emergency Departments.

Reducing pressure on EHS– delivering at place and system level

Urgent and Emergency Care services are delivered at a number of levels; within neighbourhoods, staff work across services to maintain patients in the local community where clinically appropriate; ambulance crews on scene review information within Special Patient Notes to tailor their care then liaise with that person's GP and arrange for a follow up visit, providing confidence to the patient that they will be safely managed at home.

Within each place the A&E Delivery Boards provide strategic review of local plans, enabling health and social care organisations to align priorities for care and jointly manage capacity, ensuring robust and responsive resource at times of increased demand such as winter. A&E Delivery Boards have already overseen implementation of Same Day Emergency Care and delivery of Acute Frailty services. The three boards will oversee delivery of the following at place:

- Developing a coordinated Out of Hours specification and alignment of services.
- Implementation of the Emergency Care dataset across relevant services.
- Implementation of the SAFER bundle and multi-disciplinary review of patients daily.
- Increasing joint working across health and social care including therapy and social work teams at the beginning of the acute hospital pathway.
- The development of support to High Intensity Users, frail patients and those at risk of falls.

At ICS level the three places coordinate through the ICS UEC Committee and regional expertise such as the Clinical Senate, to ensure that patients across BOB can access timely and specialist care no matter where they experience an event.

The following priorities have been identified as work at ICS level over the next 5 years for work at and ICS level:

- Review of primary care streaming at Emergency Departments and development of an enhanced model of care.
- Modelling of acute and community bedded care capacity and assessment of future need.
- Management of stranded patients and improvements to Delayed Transfers of Care.
- Implementation of the new Urgent & Emergency Care standards, when published.
- Completion of Urgent Treatment Centre designation and the coordination of same day illness and injury provision.
- Development of a workforce strategy that includes a coordinated response to the domiciliary care market and coordination of staffing in peak demand.

At supra-ICS level the development of ambulance services and Integrated Urgent Care is undertaken jointly with partners across Frimley. Across BOB & Frimley, the following services will be developed during the life of this plan:

IUC

- Increasing clinical capacity within Integrated Urgent Care.
- Providing access to rapid community response and reablement.
- Implementing MiDOS (an enhanced Directory of Services).
- Increasing direct booking into GP practices from 111.

Ambulance

- Implement a single Clinical Assessment Service across 999 and 111.
- Developing paramedic rotational posts within Primary and Community Care.
- Improving Technology and Digital enablement for 999 crews.
- Developing a Total Health and Social Care Transport solution.
- Enhancing the ability of crews on scene to manage patients in the community and avoid a clinically unnecessary conveyance to ED.

Reducing pressure on EHS - outcomes, measures metrics

BOB Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Requirements already in place			
Service	**Actions**	**Planned date of implementation**	**Delivered benefits**
Acute care	- Frailty care 70 hours per week - Same Day Emergency Care 12 hours a day - Implementation of SAFER discharge bundle providing best practice to support effective discharge - Daily Multi-Disciplinary Team ward rounds and implementation of discharge patient tracking list - Therapy & Social work teams at beginning of hospital pathway	Complete	The implementation of these services has delivered a number of benefits across the ICS, including: - Improved patient experience with care delivered closer to home - Personalised care and management of patients - Decreased clinically unnecessary Emergency Department (ED) non-elective attendances and admissions - Improved patient experience with safe return home on the same day where appropriate - Responsive and coordinated care
Ambulance	- Introduction of dedicated Mental Health vehicles - Refresh of fleet to improve life of vehicles - Global Digital Exemplar - Connectivity between Ambulance Trusts	Complete	
Integrated Urgent Care	- IUC service available 24/7 via telephone and online	Complete	
Primary Care Networks	- Establishment of Primary Care Networks - development of plans to increase capacity	Complete	
High Intensity Users	- Support established in Buckinghamshire	Complete	
Population Health Management	- Population Health Management programme in place within Buckinghamshire & Berkshire West	Complete	

Reducing pressure on EHS - outcomes, measures metrics

BOB Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Service	Actions	Planned date	Anticipated benefits
Primary Care Networks- access & care coordination	- Maturation of Primary Care Networks, with an expanded workforce and enhanced access to care - Implementation of enhanced access & urgent care specification	2019 - 2022 2021 – 2022	Delivery of these outcomes will provide a range of benefits, including: - Improved patient experience with care delivered closer to home and increasingly tailored to individual needs and the patient's own strengths and resources - Increased delivery of clinically appropriate care in the community - Improved responsiveness of services to patients with a same day care need - Support to the GP workforce, Primary Care Network and community services capacity - Reduced clinically unnecessary 999 calls and Emergency Department attendances & admissions - improvement in service performance and reduction in patient waiting times - increased opportunity for ambulance crews to manage patients on scene / in the community, reduce default conveyance to ED and having conveyed a patient, allow crews to return on road swiftly - improved coordination between services and reductions in patient length of stay and delayed transfers of care for patients receiving bedded care - Increased efficiency of service delivery and financial savings
Integrated Urgent Care	- referral to rapid community response and reablement - Expansion of clinical workforce including Mental Health and paediatrics specialists; review of palliative care support	2022 - 2023	
	- Integration of Clinical Assessment Service across 111 and 999	2020 -2021	
	- Implementation of MiDOS (enhanced Directory of Services)	2019- 2020	
	- Standardisation of Out of Hours services	2020 - 2021	
Urgent Treatment Centres	- Complete designation of facilities in Oxfordshire - Develop UTC facilities further in Buckinghamshire	2019 - 2020 2020 - 2021	
Ambulance	- Expand the Specialist Paramedic rotation model across Home visiting and other Multi-Disciplinary Teams	2019 - 2021	
	Accelerate the digital transformation, including: - Improve video links with partners including care homes - Roll out of Electronic Patient Record (ePR) Acute Interface to enable real-time information to be transmitted to acute hospitals - Ensure all ambulances have internal Wi-Fi so staff can work effectively in areas of restricted connectivity	2019 – 2021	
	Create a 'Total Transport Solution' for all non-emergency Health- and Social Care Transport and Logistics Operations	2019 – 2021	
Hospital	- Improve rapid assessment and treatment processes to support handover	2020 - 2021	
	- Improve frailty and Same Day Emergency Care services - Increase coordination with third sector and voluntary services	2020 - 2021	
	- Implement new clinical standards	2020 – 2021	
Hospital to Home	- Develop coordinated response to domiciliary care market	2022 – 2023	
Population Health Management	- Improve segmentation of population to identify and address needs - roll out of PHM approach in Oxfordshire	2020 – 2021	

Improving Mental Health – current BOB services

BOB Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Current provision and providers

Mental Health (MH) services across BOB include:

- General Practice, Primary Care and pharmacies
- Talking Therapies (including employment support)
- Inpatient Services (including Psychiatric Intensive Care – PICU - and Places of Safety)
- Community services (often jointly by NHS and local authorities)
- Child and Adolescent MH Services (CAMHS and teams in schools)
- Older People's MH Services (including Memory Clinics)
- Crisis Home Treatment
- Third sector
- MH Liaison Services in Acute Hospitals
- Early Intervention in Psychosis
- Perinatal Services
- Recovery services (colleges)
- Secure services

MH services are provided in a range of settings – the majority of people receiving treatment at home. Services are also provided in acute hospitals settings, and inpatient centres (Prospect Park in Reading & the Warneford Hospital in Oxford).

MH services across BOB are provided by:

- Primary Care Service providers – including GPs and pharmacy (40% of consultations have a significant MH element)
- Oxford Health and Berkshire Healthcare Foundation Trusts
- Buckinghamshire and Oxfordshire County Councils and Reading, West Berkshire and Wokingham Unitary Authorities
- Third sector organisations, for example including MIND, Elmore Community Services, Restore, Response and Connection Floating support, Age UK, Barnados, and Xenzone.
- Independent sector organisations, for example Thornford Park in Thatcham and Priory Wellbeing Service in Oxford.

People using the services

People of all ages are supported by MH services across the BOB area, including children and young people, adults of working age, and older people. This includes people with common MH problems, people with severe mental illness and people with complex needs.

The overall aims of the collective provision of MH services across the BOB area are to:

- promote wellbeing and preventing progression to long term mental ill health
- provide diagnosis, treatment and care to promote recovery
- prevent self-harm and suicide
- promote physical, mental health and social resilience for all people
- provide support for families and carers
- address health inequalities, with a focus on serious mental illness (SMI) and physical health, and the needs of more vulnerable groups, using population health management

We know that demand for MH services will grow. Across England, approximately 1 in 6 adults experiences a common mental disorder (such as anxiety or depression) in any given week. Half of mental health problems are established by the age of 14, rising to 75% by age 24. And in the UK, suicide is the leading cause of death among young people aged 20-34 years (Source: Nuffield Trust). Meeting the MH needs of people living in the BOB area is key priority for the ICS over the years of this plan and beyond.

Our priorities have been shaped by:

- feedback from local people about what's important to them
- review of local Health and Wellbeing Strategies in Buckinghamshire, Oxfordshire and Berkshire West
- Input of mental health commissioners, providers, clinical and managerial leaders and a cross-sector range of stakeholders
- the requirements of the Long Term Plan

Mental Health – performance & demand

BOB Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Care Quality Commission ratings

The two main provider Trusts across the BOB area (Oxford Health and Berkshire Healthcare Foundation Trusts) are both rated as 'Good' by the Care Quality Commission, and both are Global Digital Exemplars for Mental Health.

Examples of good performance

- The Oxfordshire Mental Health Partnership brings together six local NHS and charity sector mental health organisations
- The Online delivery of Talking Therapies and online peer and clinical support in a number of specialist services developed in Berkshire
- Trailblazer Peer Support in Buckinghamshire schools brings together Council, NHS and Bucks Mind
- New Care Models have been developed to deliver a range of specialist MH services improving use of resources across the Thames Valley and beyond.

Increasing rates of referrals

General practice consultations are raising by 10% each year, since 40% of referrals are mental health related. For **children and young people's Mental Health services**, overall referrals to services in Oxfordshire and Buckinghamshire have increased by 35% from 12,897 in 2016/17 to 17,372 in 2018/19. Referrals to Oxfordshire CAMHS has increased by 37%. Referrals to Buckinghamshire CAMHS has increased by 31%. Berkshire has also seen a significant increase in CYP referrals.

For **adult Mental Health services**, overall rates to Oxfordshire and Buckinghamshire Teams (Core Services) has increased by 26% between 2015/16 – 2018/19 to just below 12,000 referrals per year. Oxfordshire AMHTs have seen an increase of 28% in referrals since 2015/16. Buckinghamshire AMHTs have seen an increase of 24% in referrals since 2015/16. Berkshire has also seen a significant increase in Adult referrals.

Areas of concern

The **financial viability of core mental health services** across the ICS (in particular in Oxfordshire) is challenging and, in some areas, it is not possible to meet demand growth within existing resources

Availability (lack of) of workforce across the ICS. There is unsustainable pressure on **primary care** and Health Education England data shows a net 4% reduction each year in national **mental health nursing numbers**. This is compounded locally by the **high cost of living across the BOB area** and high levels of employment.

There is a lack of **consistency of out of hours crisis support** across the BOB area – there is a lack of support and alternatives to admission in Oxfordshire and Buckinghamshire.

High number of out of area placements across the ICS create both a significant financial risk and (generally) poorer quality for patients and carers. Berkshire, in particular, needs support of partners to achieve a sustained reduction in length of stay and therefore meet out of area placement targets.

As a relatively healthy area, our health commissioners in the BOB area **receive lower than average funding per head of population**.

Our response to people with a **learning disability** who also have mental health problems, and to people with **autism** is an area needing development.

Appropriate **housing,** supported living and a shortage of carers for people with mental health problems, learning disability and autism.

These issues have been taken into account as we have developed our 5 year plan – and are reflected in the priorities we have chosen to focus on, and the phasing of activities within the implementation plan currently in development.

Mental Health – the case for change

BOB Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

What we know – population growth

We know that demand for Mental Health services is growing and that capacity to respond is limited – both because of investment and workforce availability. This demand-capacity challenge will be exacerbated by population growth estimates.

The total population of the BOB area is expected to change from 1.68m in 2016, to a predicted 1.83m in 2036. This is an increase of 150,000 people (8.9%). The largest increases are expected to be in people aged over 60 and people aged between 13-20 years old. Population growth is likely to be greater than ONS estimate as a result of project housing growth across the BOB area. The total growth in population will drive greater demand for Mental health services – particularly those conditions more prevalent in people over 60 years old (dementia).

We also know that **life expectancy** of people living in the BOB area is lengthening for both men and women compared to England averages. Population growth will also have **economic impacts** and we already know that the cost of mental ill health to the BOB economy, the NHS, and society as a whole is estimated to be at £112 million a year.

As a result the NHS nationally and BOB plans have a priority **focus on preventing the causes of mental ill health** and intervening much earlier wherever possible in addition to joint assessment and treatment of a person's mental , social and physical health needs.

What people have told us

We have used a major Healthwatch survey undertaken this year across BOB to inform our planning, as well as stakeholder views reflected in local plans - including the strategies of local Health & Wellbeing Boards. The Healthwatch survey received more comments about mental health care than any other condition.

What people said works well (examples)

- GPs with knowledge in Mental Health
- Day centre
- Holistic support across NHS and voluntary sector services

What people said didn't work well (examples)

- GP appointments not long enough to talk about mental health
- Feeling that you're on your own after discharge
- Not being able to contact support, and long waits to treatment

What people said needs to change (examples)

- GP surgeries having specialist mental health staff & walk-in
- Holistic, empathetic assessment of mental and physical health
- Support available at the right times, and improving access

Tackling inequalities

Deprivation within the BOB area is relatively low, but there are areas of higher deprivation. We know that poverty increases the risk of MH problems and be both a causal factor and a consequence of mental ill health. Children whose parents received income and/or disability benefits are more likely to have a MH problem than children whose parents did not receive benefits. Children whose parents report poor MH are more likely to have a MH problem. Adults with severe mental illness are more likely to die younger, from a range of conditions, than adults in the general population. People with mental illness are more likely to have higher rates of: poverty; homelessness; incarceration; social isolation; and unemployment. As examples:

- psychosis is up to 15 times higher among people who are homeless compared to the general population;
- levels of psychotic disorders are 9 times higher in people in the lowest fifth of household income compared to the highest.

Mental Health – our vision for BOB

Our priorities have been inform appropriate MH services informed by the views of local people, strategies of local Health and Wellbeing Boards, our clinical and operational service leaders and the requirements of the national Long Term Plan

BOB Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Children and young people	Prompt access to help for children and young people and their families – enabling recovery from mental health problems before adulthood
Care closer to home	Crisis, home treatment and alternatives to hospital admission will be improved to enable more people to be treated at or near home. Primary Care Networks will include mental health – with providers working together to operate an integrated "front door".
Prevention	For all age groups, particularly focusing on young people - strengthened prevention of mental ill health, promoting wellbeing, reducing stigma, building community resilience
Holistic treatment & care	Improve physical health for people with severe mental health problems, learning disability and autism and promotion of health and wellbeing
Understanding need	Improving our understanding of the mental health of our population and how best to use our resources to respond to this
Workforce	A sustainable workforce enabling ongoing delivery of high quality services across the range of acuity and complexity of need, including greater use of the third sector and community assets
Infrastructure	Good quality infrastructure – including effective use of our buildings and increasing digital service delivery to support delivery of better mental health outcomes

The next 3 pages provide an overview of the work we are doing on these priorities, specific areas of focus for Buckinghamshire, Oxfordshire and Berkshire West, and an assessment of our current performance against the main Long Term Plan targets. These will all be included within our implementation plans alongside our activity, workforce and financial plans.

Mental Health – outcomes and activities

BOB Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Children and Young People
We will work to increase the number of children and young people accessing services, employ additional staff to achieve this and also make greater use of online service delivery, partnerships with schools and community and voluntary sector organisations to address workforce shortages. We will fully use transformation funding to develop MH Support Teams in schools across the BOB area, seeking recurrent funding to support increased activity required in CAMHS while reducing waiting times

Holistic treatment and care
We will provide physical health checks for people with severe mental illness, learning disability and autism and work to reduce health inequalities in terms of mortality rates. Our IAPT (Talking Therapies) services for people with long term physical health problems will be expanded with availability of recurrent funding. We will work to improve the mental wellbeing of people with a learning disability and those with autism.

Crisis response and interventions
We will develop crisis home treatment services to ensure coverage across the BOB area. We will develop alternative to admission services , (such as crisis cafes and services for high intensity users of services) and strengthen our community MH services and workforce, to reduce bed occupancy, average length of stay and delayed transfers of care from inpatient services to reduce inappropriate out of area placements. Our Urgent Care services will include effective responses to people with MH needs delivered in partnership between 111,Urgent Treatment Centers, Emergency Departments, Inpatient services and Thames Valley Police, (including street triage).
We will improve the access to a range of community based MH and wellbeing support and services through a single point of access. Third sector workers and outreach from secondary care community MH teams, will be closely integrated with general practice and PCNs.

Understanding need
We will use our developing Population Health Management capability to better understand the mental health needs of our population, how people are using our services and how best to use our collective resources to achieve good outcomes for people with MH problems. Greater service user involvement in our planning processes will ensure that services are increasingly co-produced.

Prevention
The improvement of CAMHS and perinatal services is focused on preventing long term mental health issues.
We will work in partnership with developing Primary Care Networks to provide prompt support for people with common mental health disorders We will continue to expand IAPT Services subject to recurrent funding.
Our Suicide Prevention Intervention Network will continue to work in inpatient and community settings to reduce suicide and self harm, and support those bereaved by suicide.

Infrastructure
We will deliver more services online, expand the use of technology to support our staff in their work, and develop our shared electronic records.
We will continue to develop our inpatient services to provide safe, good quality environments with availability of required funding.
New Care Models will continue to be developed, with provider collaboratives organising treatment and care on a regional basis for people with complex mental health problems.

Our place-based priorities

BOB Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

	Berkshire West	Oxfordshire	Buckinghamshire
Children & Young People	Comprehensive offer for Children & Young People aged 0-25 Mental Health Support Team roll-out Eating Disorder services	Mental Health Support Teams Improved access to 4 week waits Single Point of Access Project Tier 4 CAMHS New Care Model PICU Build	Mental Health Support Teams Improved productivity and access to 4 week waits Neurodevelopmental Conditions Service Tier 4 CAMHS New Care Model PICU Build
Perinatal Mental Health	Continue to develop and support BHFT perinatal mental health services including commitment to NICE concordat care	Transition of service to "business as usual" Launch online peer forum Digital consultations	Transition of service to "business as usual" Embed SHARON (peer-led forum)
IAPT	Expansion sustainability & workforce development. BAME access to IAPT	Expansion/Sustainability Long Term Conditions Development	Expansion/Sustainability Long Term Conditions Development
Crisis & Acute	Develop Single Point of Access for adults and children and 24/7 support with appropriate responses across NHS 111, ambulance and A&E services. Crisis pathway review to include alternatives to acute/emergency admission. Extension of Liaison Psychiatry	Improve MH care in Hospital including Liaison Psychiatry. Develop crisis alternatives across county. High intensity users programme. Patient flow programme. Inpatient process and practice	Deliver specialist Crisis Response Home Treatment Teams. Develop crisis alternatives across county. Patient flow programme. OPAL remodelling. On-site hospital support
Adult & Older Community MH Services	Community Mental Health in Primary care – PCN development. Integrated approach to substance misuse support. Physical Health for people with serious mental illness in primary care. Early Intervention in Psychosis	Implement Individual Placement & Support Physical health of people with serious mental illness - health checks. Community Mental Health in Primary care – Primary Care Network development. Complex Presentations	Implement Individual Placement & Support Physical health of people with serious mental illness - health checks. Adult Mental Health Team optimisation. Social Care considerations
Dementia & Frailty	Exploring models to support people with dementia in their own home to prevent crisis Maintaining dementia diagnosis rates.	Implementation of Dementia Strategy	Implementation of Dementia Strategy Memory Clinics Support into Care Homes
Suicide Prevention	Establish standardised psychosocial assessments in general hospitals across ICS Enhanced Bereavement Support Multi-agency plans and strategies	Establish standardised psychosocial assessments in general hospitals across ICS Enhanced Bereavement Support Multi-agency plans and strategies	Establish standardised psychosocial assessments in general hospitals across ICS Enhanced Bereavement Support Multi-agency plans and strategies
Enablers	Commitment to meet Mental Health Investment Standard Section 117 reviews to include maintaining focus on Out of Area Placements and Care Programme Approach	CCG to meet Mental Health Investment Standard MHSDS & IAPT data flow Service Directory of MH services/website improvements Workforce development	CCG to meet Mental Health Investment Standard MHSDS & IAPT data flow Service Directory of MH services/website improvements Workforce development

Long Term Plan – current progress 1

BOB Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

The tables below and on the next page shows our current status in terms of delivery against the main "fixed, flexible and targeted" deliverables for mental health within the long term plan.
Work is currently being undertaken to assess the necessary phasing of activity across the 5 years of our plan, to align with funding allocations and realistic workforce assumptions in each area.

	Fixed	Place	Flexible	Place
Perinatal	At least 4,167 women in total accessing community based mental health treatment by 2023/24	Bucks	Maternity outreach clinics in all STPs/ICSs by 2023/24	Bucks
				Oxon
				Berks W
		Oxon	Extend period of care from 12-24 months in community settings & increase availability of evidence-based psychological therapies by 23/24	Bucks
				Oxon
				Berks W
		Berks W	Evidence based assessment & signposting for partners by 23/24	Bucks
				Oxon
				Berks W
CYP	55,181 CYP aged under 18 receiving treatment from an NHS-funded community MH service by 23/24	Bucks	Comprehensive 0-25 support offer in all STP/ICS by 23/24 (published menu of approaches - 2020)	Bucks
		Oxon		
		Berks W		
	Additional 1,267 CYP aged 18-25 receiving treatment from an NHS-funded community MH service by 23/24	Bucks		Oxon
		Oxon		
		Berks W		
	95% CYP Eating Disorder standard 19/20 onwards	Bucks		
		Oxon		
		Berks W		Berks W
	100% coverage of 24/7 crisis provision for CYP	Bucks		
		Oxon		
		Berks W		
IAPT	202,487 accessing treatment by 23/24	Bucks		
		Oxon		
		Berks W		
	IAPT Long Term Conditions service in place	Bucks		
		Oxon		
		Berks W		
	Proportionate increase in access for Older People (65+) year on year	Bucks		
		Oxon		
		Berks W		

Long Term Plan – current progress 2

BOB Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

	Fixed	Place	Flexible	Place
SMI	41,170 people with SMI receiving physical health checks by 23/24	Bucks Oxon Berks W	Integrated models of primary & community crisis care across 50% of primary care networks (and 100% of ICS) by 23/24 seeing 20,417 people in the new services	Bucks
	Minimum number (3,457) of adults accessing Individual Placement and Support (IPS) services	Bucks Oxon Berks W		Oxon
	Delivery of the Early Intervention in Psychosis Standard	Bucks Oxon Berks W		Berks W
Crisis	100% coverage of 24/7 age appropriate crisis care via NHS 111 by 23/24	Bucks Oxon Berks W	Crisis alternatives in place across each ICS by 23/24 (menu of approaches 19/20)	Bucks Oxon Berks W
	100% coverage. Of adult CRHTT operating in line with best practice by 20/21 and maintain coverage to 23/24	Bucks Oxon Berks W	100% roll-out of programme for mental health & ambulances	Bucks Oxon Berks W
	70% of Liaison MH teams achieving "Core-24" standard by 23/24	Bucks Oxon Berks W		
Therapeutic Inpatient			Improved therapeutic offer to reduce average length of stay in all adult acute inpatient settings to <32 days, by 23/24	Bucks Oxon Berks W

In terms of “targeted” deliverables, we are already achieving the specified goals across the BOB area – this includes establishing mental health support teams in schools , localised suicide reduction programmes, as well as bereavement by suicide support services.

Mental Health – Workforce and Finance

BOB Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Workforce

A significant growth in workforce numbers, as well as development of new roles is required to deliver our plans. Significant numbers of additional staff will be required in Children and Young People's Services and Increasing Access to Psychological Services (IAPT) services, with growth also required in perinatal, and crisis home treatment services.

We have previously produced workforce plans for BOB, and are currently undertaking analysis of these against NHSE information about our share of the national workforce expansion, and our financial analysis. We will build on this to include consideration of Local Authority and Third Sector workforce issues, to enable cross-sector workforce planning supporting the delivery of our plan.

Workforce challenges are significant in mental health services currently, and present the single biggest risk to the delivery of our plan. We are working on the following mitigations of this risk:

- Development of new roles and skill mix
- Partnerships with 3rd Sector providers
- Online service delivery
- Recruitment and retention initiatives at organisational level
- Rearrangement of services to avoid duplication to support freeing up of workforce to focus on more appropriate functions.
- Supporting the prevention programme, building self help, peer support and use of community assets.

Finance

5 key elements are supporting delivery of our plan, recognising the required scale of increased access, delivery of new service models and effective response to growth:

Funding in response to agreed demand growth assumptions in mental health is a key priority and is subject to decision-making between commissioners and providers at "place" level in Buckinghamshire, Oxfordshire and Berkshire West.

Five Year Forward View and LTP Funding which has previously been committed to nationally has been assumed as ongoing.

Uplift to CCG budgets to support delivery of mental health aspects of the LTP has been included in our planning in line with national assumptions.

Specified time-limited **Transformation Funding** is also linked to the delivery of LTP targets. Our ability to achieve these on an ongoing basis is contingent on availability of recurrent CCG funding.

Efficiency savings will continue to be required at organisational level – recognising that a significant effort is required to minimise waiting times as we increase access to services.

Analysis of the above sources of investment across the 5 years of the plan is currently being undertaken, to inform both system planning and organisational financial plans.

Mental Health – 5 year plan summary

BOB Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

	2019/20	2020/21	2021/22	2022/23	2023/24
Children and Young People	Mental Health Support Teams in schools across BOB	Implementation of access/data collection plans across non NHS providers	Scale best practice use of online delivery 0-25 delivery model confirmed	Evaluate MH Support Teams and modify approach as needed	
Care closer to home	Completion of plans for integration with PCNs CRHTT development	Liaison service development subject to funding	Implement agreed model in partnership with 111 provider	Evaluate impact of crisis services, including alternative models	
Prevention	Bereavement by suicide support MH integration with Primary Care Networks				
Holistic treatment and care	Health checks delivery Berks West	Maintain positive performance in EIP/IPS	Scale best practice use of online delivery Integrated model agreed with PCNs		
Perinatal services	Completion of analysis of resource needed to meet access target	Implementation of plans post review of clinics	Completion of plans for partner support		
IAPT	Expansion of treatment of common mental health disorders Long term conditions expansion		Recovery of access targets across Bucks/Oxon subject to funding/recruitment		
Therapeutic inpatient	Sharing best practice and confirm reciprocal agreement to reduce out of area placements	Use of Quality Improvement methodology to identify specific actions	Implementation of agreed model and best practice sharing across BOB		

Improving Cancer outcomes – BOB approach

BOB Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Executive Summary

This is the Buckinghamshire, Oxfordshire and Berkshire West (BOB) Integrated Care System's approach to delivering the NHS Long Term Plan ambitions for cancer. Our approach forms part of the Thames Valley Cancer Alliance's (TVCA) 5-year strategy for cancer developed in response to the long term plan for cancer with a focus on our achievements to date, our challenges now and for the future and how we plan to address them.

In line with TVCA, our cancer vision for our population is simple:

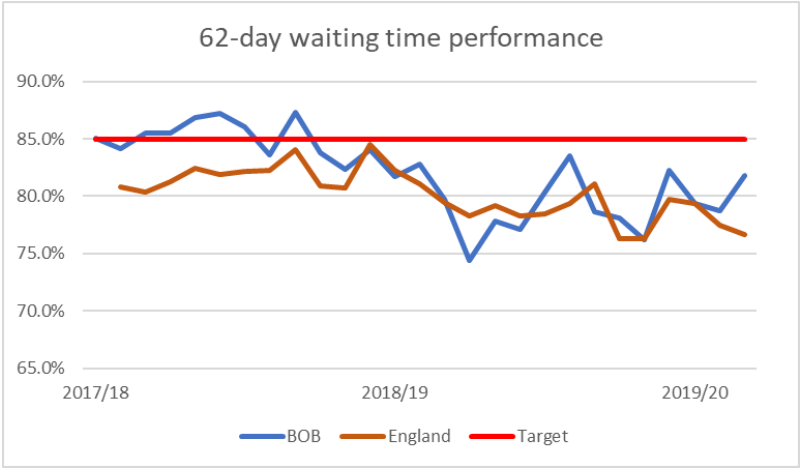
*To create a region that secures and delivers the **best possible outcomes** for every patient affected by cancer by **working together** to maximise resources, to deliver the best possible, **clinically-led** and **patient driven health and social care** so that every person affected by cancer receives the best possible outcomes.*

The NHS Long Term Plan sets important and stretching ambitions for transforming cancer care and we continue to work with and through Thames Valley Cancer Alliance to agree and deliver a system-wide plan covering both **operational performance and transformation.** While we are a high performing system, we recognise we have more to do to improve the outcomes for people affected by cancer including delivering the NHS Constitutional standards for cancer treatments for the population we serve.

Our approach contains our collective proposals for action and describes the ambitions of the transformation programmes we are undertaking and sets out the high level work programmes for how we will continue to deliver the recommendations of the cancer ambitions within the Long Term Plan.

Where we are now

Achieving the national cancer waiting time standard of 62 days between referral and beginning of treatment continues to be a challenge across BOB. As a system we have not achieved the standard since December 2017 – this means that more than one in seven cancer patients are now waiting longer than 62 days to start treatment following an urgent GP referral. The 62-day standard is the only standard which considers the patients' entire pathway journey from referral to treatment which may explain why performance has been worse relative to some of the other cancer standards. Delays in any area of care have an impact on patients. But in cancer care, the amount of time a patient waits for diagnosis and treatment can significantly affect outcomes and experience.



Thames Valley Cancer Alliance – DRAFT 5yr Strategy

BOB Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Our Mission and Vision

To achieve our vision we will operate within a defined set of principles and use fixed points for measuring our success using the five 'lenses' as our guiding principles. We recognise that each of our members work for separate statutory organisations however we will work as an alliance with shared aims and ambitions and have agreed the following principles of how we will work to achieve our shared aims and ambitions for the benefit of patients.

Mission

The mission is simply about **saving lives**. By **reducing incidence** and **improving treatment** and **survival**, so that our cancer incidence is as low as possible, our survival rates as high as possible and the quality of care provided enables people to return to **healthy productive lives, supported** to deal with any long-term consequences from their cancer experience.

Vision

To create a region that secures and delivers the **best possible outcomes** for every patient affected by cancer by **working together** to maximise resources, to deliver the best possible, **clinically-led** and **patient driven health and social care** so that every person affected by cancer in Thames Valley receives the best possible outcomes.

Our Principles

- To work as a single alliance and act with common purpose to deliver high quality sustainable cancer prevention, treatment and care to the populations we serve;
- To continue to develop the culture and behaviour change to deliver the shared vision and strategy;
- Promote system wide planning and action with structures and systems to support the delivery of a shared strategy;
- Reduce duplication and variation;.
- Celebrate and share successes and learning.

Operating Model

Strategic Priorities

1. Prevention - Reduce smoking prevalence to 10.8% by 2021; Prevent avoidable cancer deaths
2. Early Detection - Increase screening uptake / coverage of national cancer screening programmes
3. Early Diagnosis - Increase early stage diagnosis (1 & 2) to 60% and increase one-year survival to more than 75% by 2028
4. Fast, Effective Care & Treatment and achievement of of sustainable operational performce
5. Personalised Care - Ensure everyone diagnosed with cancer will have access to Personalised Care by 2021
6. Patient & Public Engagement - Provide improved patient experience to achieve 9/10 in the National Cancer Patient Experience Survey
7. Workforce

Points for measuring success

- The NHS Constitution;
- The NHS Outcomes Framework;
- Delivering within budget;
- Statutory duties including promoting equality and reducing inequalities.

Five 'Lenses'

- Quality – contribution to the NHS Outcomes Framework;
- Clinical leadership;
- Patient and public voice;
- Equality and health inequalities;
- Innovation and the NHS change model.

Cancer – performance & demand

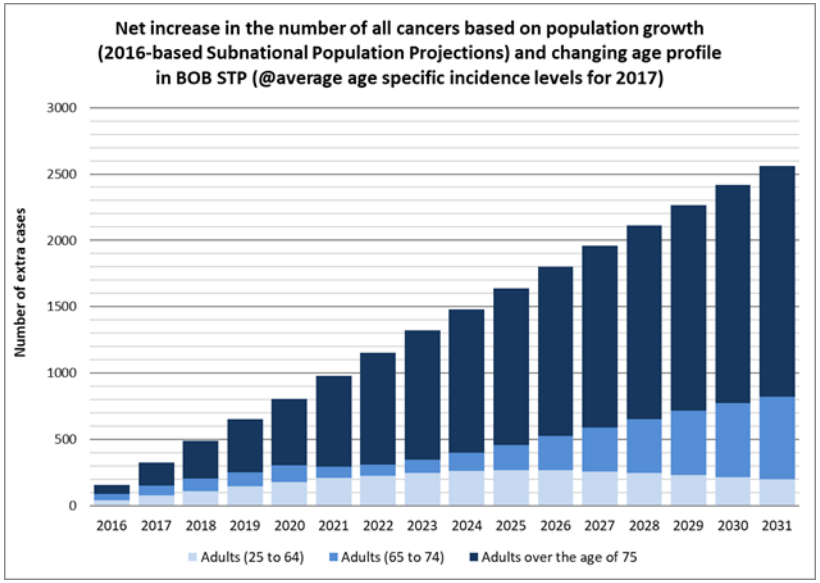
BOB Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

The challenge

Data suggests that the increased number of referrals is placing additional strain on cancer services, with demand outstripping the current resources available. Patient demand for cancer services is increasing significantly. In 2017/18, almost 2 million patients nationally were referred by their GP for suspected cancer, equating to more than 5,000 patients every day. When compared to five years ago, this is an increase of almost 60%.

The increase in the number of GP referrals is due to a combination of different factors including the changing age demography of the UK population, the increasing awareness of the disease driven through national campaigns, celebrity announcements and changing medical practice, guidelines and referral thresholds.

Although performance has slipped against the cancer targets, it is important to note some of the positives which emphasise the exceptional care that trusts continue providing patients despite the immense pressures on these services.



Examples of demand:

- There were 97,710 GP referrals for suspected cancer seen to Thames Valley's hospitals in the 12month period of Aug 18-Jul 19, up from 89,355 in the previous year.
- Although there is a lot of variation, the incidence and death rates across Thames Valley are lower than England and there is scope for significant improvement in the rate of early diagnosis.
- Across Thames Valley less than half of patients are diagnosed early[1] and there is direct correlation in areas with greater deprivation and poorer one-year survival rates.
- There is significant variation in cancer screening uptake/achievement across Thames Valley at ICS/STP, CCG and practice level. Implementation of targeted initiatives including the Alliance's Quality Improvement Scheme (QIS), and promotion of education and awareness of the importance of screening are crucial to supporting improvement in cancer screening uptake/coverage across Thames Valley.
- Whilst the 1-year and 5- year survival rates are higher than the national rate, the aggregated figures masks a wide disparity in survival depending where the patients live (see 1-Yr survival index chart above). The chances of surviving one year after diagnosis of cancer are less than 72% in Swindon but more than 74% in the more affluent areas of the region eg parts of Oxfordshire and Frimley.
- Earlier diagnosis - Multiple workstreams are in progress across the Alliance to promote earlier diagnosis of cancer. Each of our systems is implementing the timed best practice pathways for Lung, Prostate, Lower Gastro-intestinal and Oesophageal-gastric cancers and a new multi-disciplinary diagnostic centre model (MDC) for non-specific but concerning symptoms.

Cancer – performance & demand

BOB Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Examples of demand (cont)

- Data suggests that the increased number of referrals is placing additional strain on cancer services, with demand outstripping the current resources available
- Over the last five years, breast screening uptake across Thames Valley has decreased to 74.5%; whilst higher than the England average (72.1%), it is below the accepted national target of 80% uptake. Bowel cancer screening uptake across Thames Valley has increased, now above the national target of 60% (61.6%). The introduction of FIT for bowel cancer screening, a more sensitive and easier test to use, has been shown potential increases in uptake of 7% and above. Support the roll out of FIT for bowel screening
- Earlier diagnosis - Multiple workstreams are in progress across the Alliance to promote earlier diagnosis of cancer. Each of our systems is implementing the timed best practice pathways for Lung, Prostate, Lower Gastro-intestinal and Oesophageal-gastric cancers and a new multi-disciplinary diagnostic centre model (MDC) for non-specific but concerning symptoms.
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Approaches

Speed up pathways to treatment - We will build on the work to reduce diagnostic waiting times to agree and implement new pathway that see patients beginning their treatment within the current standard of 62days.

Review Diagnostic Capacity - Establishing system-wide pathology and diagnostic-imaging networks to reduce diagnosis waiting times. We will undertake a review of diagnostic capacity utilising a variety of sources to answer a set of 'exam' questions to identify the current demand for diagnostics; how much is for cancer; current capacity available; associated diagnostic workforce capacity and how to ensure future demand can be sustainably met.

Radiotherapy ODN - The Alliance will continue to support the establishment and running of the Thames Valley & Wessex Radiotherapy Network. In addition to the requirements set out in the national specification for radiotherapy, the network will lead the development of radiotherapy aspects of standards of care and the role of clinical oncologists in MDT streamlining.

Precision Medicine - Working with partners, to enable patients to benefit from the latest advances in genomics and personalised medicine, including reducing the time it takes to receive a diagnosis for a rare disease and improving survival outcomes for those with aggressive cancers, as well as embedding whole genome sequencing as part of routine care.

Cancer - outcomes and activities

BOB Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Activities

We are fully committed to ensuring all those affected by cancer will receive the most effective, precise and safe treatments, with fewer side effects and shorter treatment times.

Within BOB we aim to achieve this by:

- Continuing to work with partners to ensure implementation of all national best practice cancer pathways;
- Continuing to work with and through TVCA and partners to deliver all Constitutional Standards for cancer;
- Providing support to strengthen Multi-Disciplinary Team meetings in partnership with cancer site specific group clinical leadership;
- Seeking investment in new equipment and treatments, including CT and MRI scanners, advanced radiotherapy techniques and immunotherapies;
- Supporting the Alliance to establish the Thames Valley & Wessex Radiotherapy Network;
- Supporting the delivery of the updated service specification for children and young people's cancer services;
- Continuing to support equality of access to clinical trials;
- Continuing the spread of access to community-based chemotherapy;
- Ensuring that during the next ten years all people with cancer who could benefit from genomic and molecular testing are able to do so

Personalised Care

The NHS Long Term Plan ambition: ***By 2021, where appropriate every person diagnosed with cancer will have access to personalised care, including needs assessment, a care plan and health and wellbeing information and support – delivered in line with the NHS Comprehensive Model for Personalised Care.***

Personalised care is based on what matters to people and their individual strengths and needs. Empowering people living with cancer to take control of their care is a priority within the NHS Long Term Plan.

Across BOB we continue to work with TVCA to align the Living With and Beyond Cancer programme with Personalised Care to enable the building in of the personalised care comprehensive model to the cancer recovery package including:

- implementing personalised care is based on assessment of needs through Holistic Needs Assessment (HNA) and Patient Activation Measures (PAMS) throughout the patient pathway. The HNA and PAM enables indication of whether further assessment is required for support for physical activity and exercise, nutrition and/or psychological support and behaviour change at a universal, targeted or specialist level.

- Personalised care and support planning development with Macmillan – 'What about me? and what matters to me?' added to the henna

- All those affected by cancer have access to all four elements of the recovery package.

- Working with Macmillan on PCSP and embedding personalised care – 'Right by you' strategy

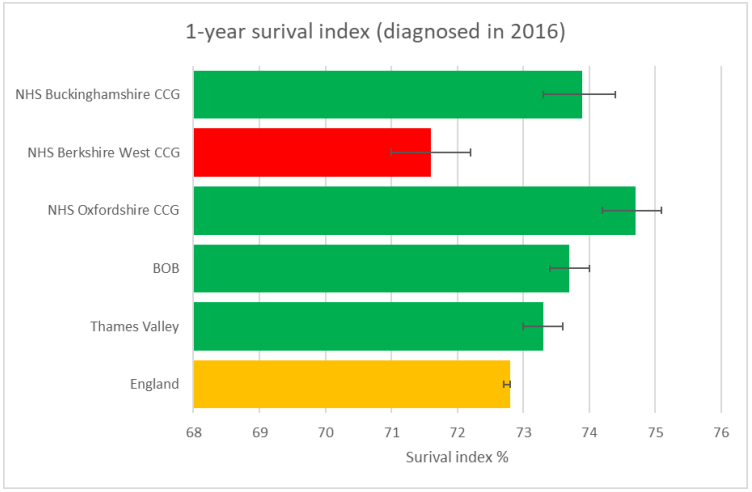
Cancer – Improving the 1 year survival rate

BOB Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Cancer Survival

The NHS Long Term Plan ambition: ***from 2028, 55,000 more people each year will survive their cancer for at least five years after diagnosis.***
The Long Term Plan survival ambition aims to place England among the best countries in Europe for survival. 55,000 more people surviving their cancer for five years is equivalent to 5-year survival reaching about 70% from an estimated 55.5% in 2015.

The BOB population has a history of good cancer outcomes and the overall chance of surviving one year and 5-years following a diagnosis of cancer continues to increase year on year and remains above the England average and comparable areas except within Berkshire West where one-year survival is very poor and well below the England average.

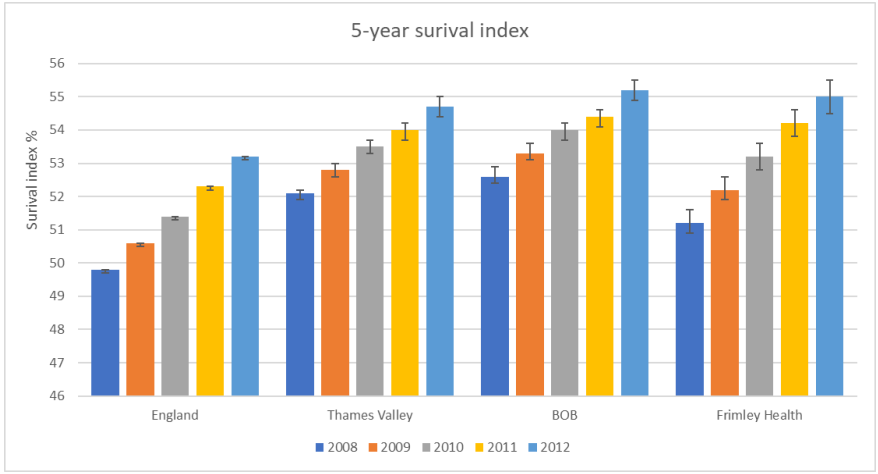


One Year Survival from Cancer

	2016 (Baseline)		2019/20	2020/21	2021/22	2022/23	2023/24
Rate	73.30%						

Proportion of cancers diagnosed at stages 1 or 2

	2017 (Baseline)		2019/20	2020/21	2021/22	2022/23	2023/24
Numerator	5,078						
Denominator	9,097						
Rate	55.82%						



Cancer – earlier and faster diagnosis

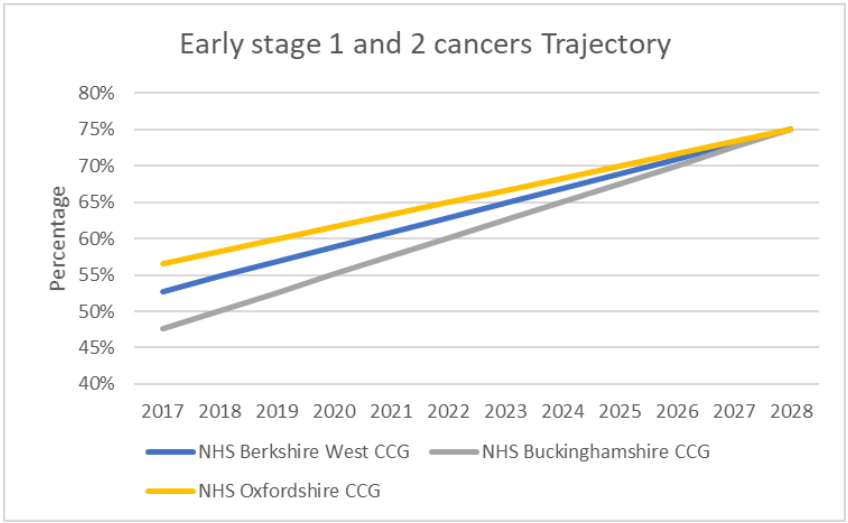
BOB Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Earlier and faster diagnosis

The NHS Long Term Plan ambition: ***by 2028, the proportion of cancers diagnosed at stages 1 and 2 will rise from around half now to three-quarters of cancer patients***
To diagnose 75% of cancers at early stage demands a different approach – the metric covers all cancers and will require improvement for the rarer as well as the higher volume cancers.

This is something we recognised in 2017 when we set a local ambition of increasing the proportion of cancers diagnosed at stage 1&2 to 75%.

Although we have not yet achieved this ambition, as a system and Alliance we have continued to increase the proportion of cancers diagnosed at stage 1&2 where currently across BOB 52.6% (2017) of staged cancers are diagnosed at stage 1 or 2. The highest early diagnosis rate is within Oxfordshire CCG at 58.3% and the lowest diagnosis rate is within Buckinghamshire CCG.



Only two cancers have early diagnosis rates above 75% (breast and melanoma) with two others above 60% and some remain low, below 30%.
Some of the interventions that will deliver earlier diagnosis are ready to implement, while others require further development and testing as we begin to deliver the Long Term Plan.

Status of Intervention	Programme
2019/20 Implementation	Improving screening uptake – QIS rolling programme Roll-out of FIT (Faecal immunochemical test) NOBP Pathways – rolling programme Rapid Diagnostic Centre (one in each Alliance) Reducing variation working in partnership with citizen panel Improving GP referral practice – rolling programme
Further development required as part of 5-yr strategy	Rapid Diagnostic Service (implementation plan for expansion) Application of precision medicine (genetic and molecular) Accelerating the translation of innovation and research into routine clinical practice

Cancer – smoking prevalence

BOB Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

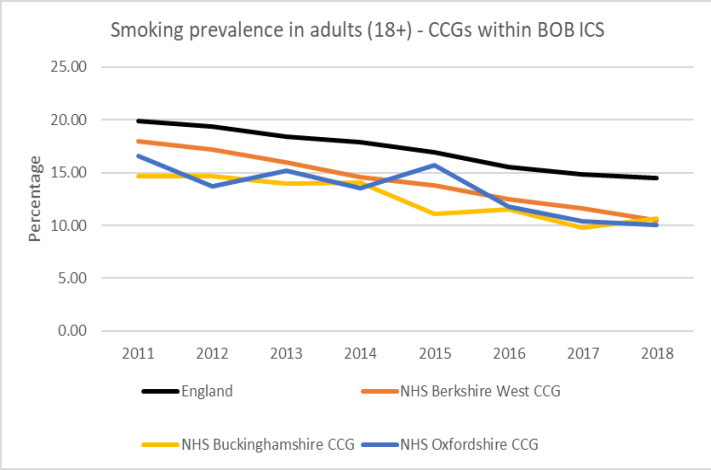
Smoking Prevalence

In 2017 Thames Valley Cancer Alliance set an ambitious target of reducing smoking prevalence to 10.8% from a baseline of 15.4% (30% reduction based on the projected 2021 population).

For the population of BOB this meant a reduction from 14.7% to 10.3%. As can be seen in the chart below – this has been met with some areas exceeding the target. Whilst this is extremely positive there are still challenges to overcome when looking at smoking rates within the socioeconomic groups - particularly within routine and manual workers in Berkshire West which is worse than the England average.

To ensure we sustain and accelerate the upward survival trend, we need to continue to make progress in three key areas:

- Diagnose more cancer early;
- Identify and reduce variation in access, practice and outcomes for patients;
- Ensuring faster translation of innovation and research into practice.
- We will draw on Public Health England's Place Based Approaches to Reducing Health Inequalities and the Menu of Evidence Based Interventions to identify, support and resource improvements in the areas of poorest survival.



Socioeconomic group (18-64 yrs) in year 2018	England	NHS Buckinghamshire CCG	NHS Oxfordshire CCG	NHS Berkshire West CCG
Managerial and professional	10.17	6.96	6.62	7.75
Intermediate	15.75	17.27	12.90	10.90
Routine and Manual	25.40	21.31	16.99	24.46
Never worked and long term unemployment	18.53	11.54	15.03	11.46

Shorter waits for planned care - surgery

BOB Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Our Vision

- Delivery of the LTP expectations through targeted action on challenged specialities and being a first mover on OP transformation
- Improved health outcomes and improved experience for our patient population through implementation of best practice models and a reduction of variation in clinical practice across the ICS
- Improved access to seamless, holistic services that meet our patients needs at the earliest possible opportunity.
- Raise the profile of prevention within our services promoting pro-active care rather than reactive treatment
- As far as possible individual's care needs are met in their local community with a reduced need for hospital based care.

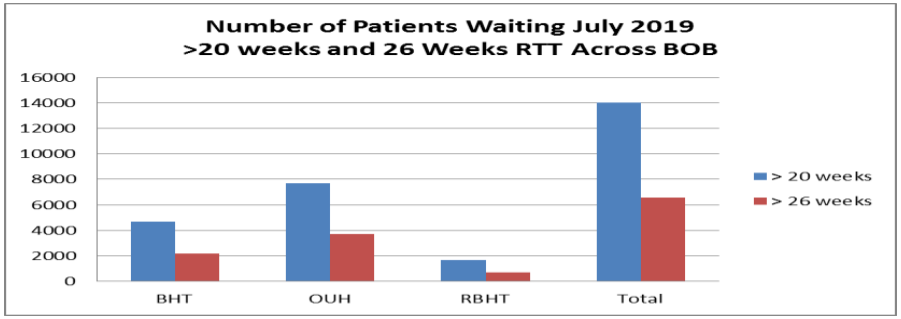
Key Aims of the BOB ICS Planned Care Programme (the Acute Collaboration Workstream (ACW)

- Streamlining outpatients services through adoption of digital tools that support activities such as virtual consultations to increase access and a reduction in face to face consultations by c. 627,435 consults, (2018/19 data), over a five year period. This is based on the patient being seen in the right place first time and seeing the right healthcare professional.
- Implement targeted improvement programmes in challenged services such as Ophthalmology, ENT and Musculoskeletal (MSK) and gynaecology to deliver an increase in planned surgical productivity that reduces waiting times of over 52 weeks by end of Mar 2020 .
- Implement the national 'Choice ' programme by April 2020 to offer 'choice' of alternative provider to patients who have waited over 26 weeks to reduce waiting times to within 18 weeks by 2024.
- By 2023/24 provide access to First Contact Practitioners (FCP) plus online digital support for all patients with MSK conditions across ICS.
- In line with the reduction in waits reducing the size of the overall waiting list to within the March 2018 out turn levels over a five year period.

Context

The BOB ICS offers its outpatient and planned surgery across a local geographical footprint in the south-east with a population of c. 1.8 million extending to a broader catchment up to 2.2 million reflecting its specialist service activity through its clinical networks. The most densely populated areas are in Aylesbury, Oxford & Reading with 22.74% of its population residing in market towns, villages and more rural areas which represent specific challenges in view of reaching patients with technology and also transport links. There is a better than average life expectancy and lower levels of deprivation than England.

The main challenges for the ICS are an increase in demand for healthcare as a result of an increasing population in the area , pockets of deprivation and in parts of Oxford & Reading and a high percentage of frail elderly people with co-morbidities. As a result there is high demand for specific services which is reflected in the number of patients waiting over 20 and 26 weeks for treatment shown in the chart below:



There are widespread difficulties across the BOB health sector with staff recruitment and retention due to the high cost of living. In many parts of the BOB healthcare sites services are being offered out of an aged estate which does not facilitate efficient working. There is variable access to some specialised services across BOB which includes obesity services.

Shorter waits for planned care - surgery

BOB Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Challenges

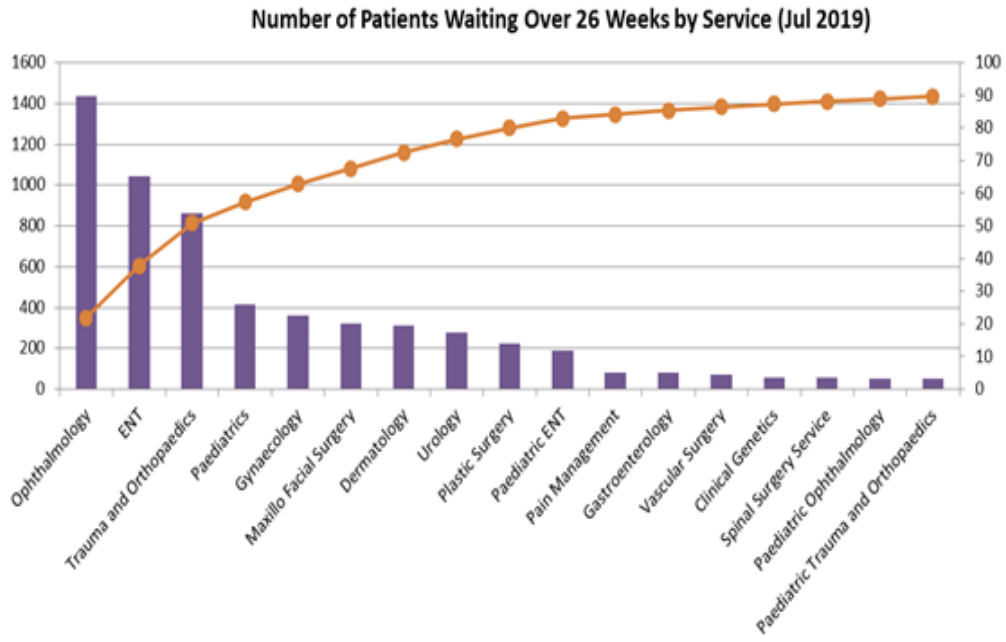
There are a total of 77 services across BOB with significant operational pressures and as a result are demonstrating a deteriorating Referral to Treatment Time (RTT) to below 92% which is the national standard of patients having started treatment within 18 weeks . As at the end of July 2019 there are 6,575 patients waiting over 26 weeks for treatment.

The Chart below shows 17 services where the pressures are at their most acute for a number of reasons which include a high demand that is outstripping available capacity e.g. Ophthalmology and ENT, enhanced screening picking up new disease as can be seen in Urology, changes in workforce that leave a void in services until posts are filled e.g. Dermatology and services where pathway redesign is required to maximise utilisation of capacity across BOB e.g. gynaecology

Information provided by the South Central Commissioning Support Unit, NHS Right Care and Dr Foster supports that there are improvements to be made in elective care across BOB which could significantly relieve the pressure in these services.

NHS Buckinghamshire CCG	NHS Oxfordshire CCG	NHS Berkshire West CCG
• 2.3% of patients did not show for their first appointments. • This cost £120,648.00 and 914 appointments were lost. • 1.7% of patients attended late, of which 333 had to be booked for another appointment	• 4.1% of patients did not show for their first appointments. • This cost £140,580 and 1065 appointments were lost. • 8.6% attended late, of which 929 had to be booked another appointment.	• 5.3% of patients did not show for their first appointments. • This cost £121,308 and 919 appointments were lost. • 1.3% attended late, of which 177 had to be booked another appointment.

60 days of Ophthalmology first appointments lost across BOB STP due to patients not 'showing'



A total of 810 elective operations were cancelled across BOB providers for non-clinical reasons in the 6 months up to September 2018. An example of where improvement could be made is shown in the figure above from BOB wide Ophthalmology services where a total of 2,898 were lost over a 12 month period 2018/19.

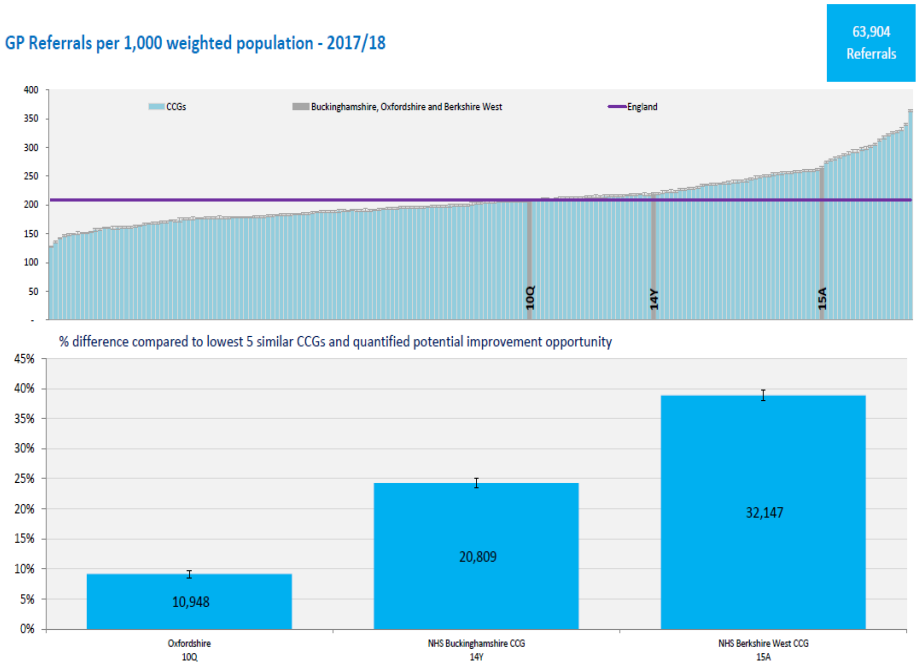
Shorter waits for planned care - surgery

BOB Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Challenges

The benchmarking data such as that provided by NHS RightCare are being used within ICP's such as Berkshire West within their Outpatient Transformation Programme, to inform where there are unwarranted variations in practice as compared with CCG peer groups. This information provides opportunities introduce best practice models, release capacity and reinvest to support other services under pressure. The chart below shows GP referrals per 1000 weighted population by place as compared with peers.

There are c.120 more referrals per 1,000 weighted population in West Berkshire compared to national rate (2017/18. There are also variations in referral rates into specific services such as gynaecology.



STP Opportunity calculated by summing the CCGs with statistically significant opportunities
Source: Operational Information for Commissioning (NHS England)

The RightCare data are not only being used to demonstrate variations in practice but also to inform where improvements could be made in prevention and detection of those patients at high risk of developing conditions that would require planned care in the future e.g. those patients with diabetes at high risk of developing cataracts.

The information below demonstrates where across BOB an increasing focus on prevention could have an impact on reducing the need for planned elective surgical care and will improve outcomes for patients:

1 Prevention & Detection

Cancer
- 11,310 fewer people screened for cervical cancer
- 4,088 fewer people screened for bowel cancer
- 2,862 fewer people screened for breast cancer

Circulation
- 5,687 fewer reported to estimated cases of Hypertension
- 5,262 fewer reported to estimated cases of CHD
- 1,262 fewer reported to estimated cases of AF

Endocrine
- 9,006 fewer reported cases of Diabetes

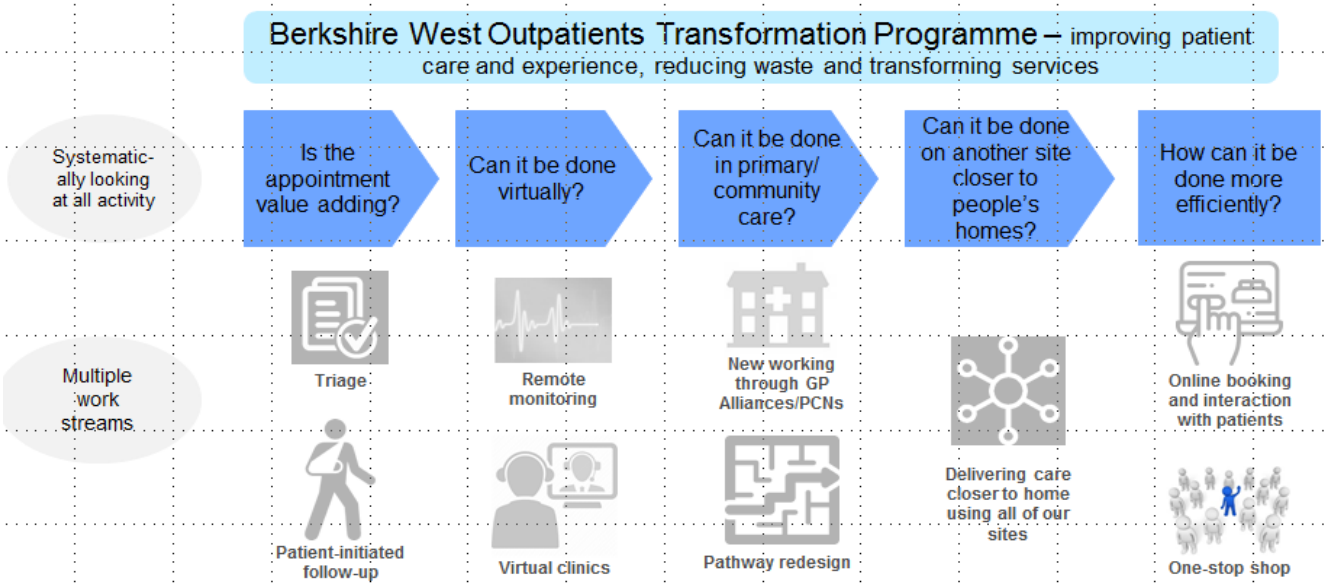
Respiratory
- 1,434 fewer people (>65+yrs) received PPV vaccination
- 5,967 fewer reported to estimated cases of COPD

Shorter waits for planned care - surgery

BOB Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

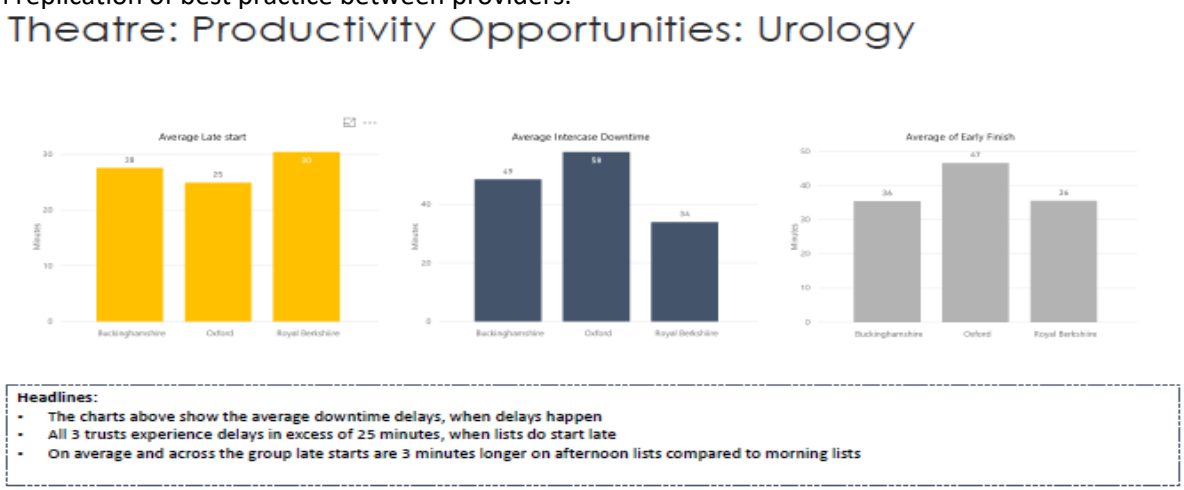
Opportunities

The work on improving efficiency and streamlining of out patients services across BOB is extensive ranging from creation of a best practice model checklist for outpatients provision in Berkshire West from their Outpatients Transformation Programme to innovations using technology where women diagnosed with diabetes in pregnancy can remotely monitor their blood glucose levels. This reduced Outpatient visits and improved monitoring of their condition. This is now a permanent clinic for women in North Oxford



Despite this fantastic and in some cases ground breaking work there is room for improvement with over **149,000 clinic slots not attended** (DNA's across the system each year, **nearly 600,000 outpatient slots cancelled** each year and only **up to 20%** of our outpatient consultations held using non face to face contact. Benchmarking across specific pressured elective services in BOB demonstrates that the ICS could rectify its adverse position on Referral To Treatment if efficiency could be improved through replication of best practice between providers.

The example shown is in Urology services where reducing late starts and early finishes in theatres could increase the potential for a minimum additional 861 cases per annum across BOB (additional 17 cases per week).



Shorter waits for planned care - surgery

BOB Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Opportunities

The implementation of the First Care Practitioner pilots is underway across GP practices in BOB with progress and outcomes being evaluated.

The pilots were developed within NHSE and Health Education Guidance to deliver to a framework as demonstrated by the Berkshire West ICS teams below:

1st Contact MSK Service

- Frist Contact MSK Sessions run on **Wednesday and Thursday Mornings**
- For patients asking for an appointment for a joint or muscle problem

Reasons to have a 1st Contact MSK Assessment

- Receive an extended assessment of their problem (20mins)
- Be assessed by a specialist MSK Practitioner
- Gain a more thorough diagnosis of their problem
- Allow time for demonstration of exercises that will help them recover sooner
- The option to be seen in another practice if more convenient

Booking Checklist – 4 Tests

1) Is the patient concerned about **more than 1 area of their body?**
2) Does the patient have **any other concern** that might necessitate a GP appointment?
3) Has the patient **seen the GP before about the issue?**
4) Have the symptoms been **presenting for 3 months or more?**

Patients answering **"YES"** to any of the above are considered **inappropriate** for this service any may have the needs better met by a GP appointment.

Booking on Vision360

- Log into the **"Newbury Cluster"** Vision360 Shared appointment book
- Find a **FCP MSK** session (available 2 weeks in advance)
- Offer the patient a free appointment slot, in a practice convenient for them
- If the patient accepts an appointment, book their chosen appointment and provide the following information in the comments box:

1. Patients **presenting complaint**
2. **Practice** the patient is registered with
3. **IT system** of registered practice (e.g. EMIS, Vision, TPP)
4. Any **special requirements** should be noted, such as interpretation service required. (Arrangements for special requirements will need to be put in place in advance by the "home" practice)

NOTE: When booking a patient into another practice, please provide the patient with the corresponding address.

Special booking (System One Patients)

- If you are unable to find a patients information in Vision360 you can book the patient in as a special booking.
- When making a special booking please provide the following additional information in the comments box:

1. **Date of Birth**
2. **NHS Number**

The FCP roles put in place are qualified autonomous clinical practitioners who are able to assess, diagnose, treat and discharge a person without a medical referral – where appropriate. This involves a shift from the traditional provision of community or hospital-based therapy services to physiotherapists being part of the frontline general practice team. They can be accessed directly by self-referral or staff in GP practices who can direct patients to them. While FCP services will move a significant proportion of the MSK workload from GPs, it is not intended to deskill GPs. GPs will continue to see a proportion of MSK patients; with FCPs providing advice and expertise into the whole GP team. The Chartered Society of Physiotherapy (CSP) estimates that physiotherapists working as FCPs could see up to half of all patients with MSK conditions (up to 40% of all patients currently being seen by GPs). Following the implementation of the pilot the following benefits have been seen in line with other pilots:

- Quicker recovery for patients with 50-70% discharged after 1 consultation
- The integration of Shared Decision Making early into a patient's pathway
- Improved use of diagnostic capacity with 3-5% cost reductions in plain X-rays and MRI scans ordered from general practice
- More appropriate referrals into secondary care, reflected in improving conversion rates for orthopaedic surgery (80 – 99%)
- Good patient experience with 90-99% satisfaction rates in pilots

It is the intention of the ICS to learn from the pilot sites through the ongoing monitoring and evaluation and to roll out the FCP model across all PCN's. Initial planning demonstrates that this will take a period of five years given that senior staff are difficult to find and recruit. Additional funding will be required along with the commitment to support the ongoing personal development requirement of these extended roles.

Shorter waits for planned care - surgery

BOB Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

How Will We Achieve Our Aims

The BOB ICS has formed a working group called the Acute Collaboration Workstream to provide an integrated approach on system pressures in planned care. The ACW is one of 9 work streams identified within the BOB ICS Strategy to focus on driving efficiency, increasing productivity, reducing waiting times, reducing pressure of demand and releasing capacity across the whole system for planned care.

The mandate of the ACW is to establish a cohesive system wide approach to managing specific challenges within 'planned' healthcare across the Buckinghamshire, Oxfordshire and Berkshire Integrated Care System (BOB ICS).

- The ACW will establish a common cause across organisations with the purpose of improving services, systems and processes in support of the population we are serving.
- The ACW will add value through aligning its priorities to the following areas:
- Short term brokerage of solution where there is a service interruption or critical need in one or more organisations
- Potential for service delivery at scale through changes in the provider model
- Pathway and service specification development where there are benefits to having a system wide agreement on common clinical pathways
- Collating information and sharing insight

The membership of the ACW comprises representatives from across local authorities and public health to clinical networks, primary care, CCG's, acute trusts, community care and other supporting organisations such as the voluntary sector.

The ACW apply a set of agreed criteria to determine the priority of the issue raised and agree the approach to be used to each of the current and future challenges as they arise. Using this approach the ACW has already identified a pipeline of priorities for 2020/21 this includes:

A BOB ICS Targeted Outpatient Programme supported by NHSEI.

Bariatric Surgery - Since the devolution of commissioning of this service the provision of the Tier 1 – 4 care (from self-management to surgery) has been poorly defined across BOB. The data on demand and capacity and projections for growth need to be better understood in order to determine a strategy for BOB wide delivery This issue has been raised across the system as an item that needs BOB ICS input to map the current state and make a proposal on a system wide solution that will improve outcomes for patients in this area of unmet demand.

Diagnostics are a focus of attention within the ACW improvement programme due to the considerable pressures within the elective and urgent care pathways as a result of constraints in access to diagnostics and in particular MRI and endoscopy. The project will focus on access and delivery of diagnostics across BOB which starts with a system wide mapping of what is available in terms of facilities (including plans involving capital development e.g. increases in MRI scanners etc), equipment which includes access to new technologies such as image sharing platforms for remote reporting and virtual consultations and human resources in particular those areas where success planning needs to occur to support services which are rendered vulnerable due to rapid expansion in demand or where there are staff with specific expertise who are retiring from post.

A Framework Agreement – to support joint decision making and utilsation of capacity across providers where there are system pressures. Five such areas (Gynae, Urology, Orthopaedics, Dermatology and Pathology) were identified through the data triangulation (NHS Delivery Unit: Bronze Pack. This piece of work is particularly important to the ICS discussions and planning to meet the LTP expectations to reduce waiting lists overall through improving access, through increased utilisation of capacity across BOB providers, reducing >52 week waits to 0 and offering choice to all patients waiting >26 weeks. The ICS is in the process of undertaking joint planning to develop a process for identification of patients waiting in excess of six months and a robust process for tracking and monitoring their choice decisions. The Framework Agreement is critical to those discussions and implementation of plans that need to be put into action at pace.

Shorter waits for planned care - surgery

BOB Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

The BOB ICS Targeted Outpatient Programme

The BOB ICS has made the joint decision to modernise and redesign its outpatient services so that both patients' time and specialists' expertise are utilised to best effect. All out patients services (including those in mental health) are within scope of the BOB ICS programme.

The foundation of the programme is evidence based and will work on the following principles that have been proven as high impact interventions; That outpatients services traditionally serve at least three purposes, and in each case there are opportunities for redesign: (1) Advice and Diagnosis; (2) Post-Procedure Review; (3) ongoing specialist input for long-term conditions. Based on these principles the programme will:

- Review pathways to implement best practice and avoid unnecessary activity e.g. unnecessary referrals, multiple follow-ups, diagnostics before first outpatient attendance
- Maximise use of non-consultant-delivered clinics e.g. nurses, AHPs, where clinically appropriate
- Reduce unwarranted variation
- Maximise use of technology and virtual working.

System partners have come together to work on a phased approach to building the most efficient outpatient models of care that it can across the whole of the Buckinghamshire Oxfordshire and Berkshire West Region recognising that our patient care is a continuum and crosses boundaries of care. An analysis of the pressures in demand for out patients services has demonstrated the following areas for prioritisation as a first phase of a five year improvement programme

Targeted Outpatient Programme Aims

In June 2019 the BOB ICS (wave 3) had support approved for input from the NHSEI Elective Care Delivery Team for a pan system approach to improvement of its outpatient services which includes using digitisation as an enabler to improve access and efficiency.

The key ambitions for the programme have been developed in line with delivery of the Long Term Plan (LTP) principles and includes:

- Development of a clinically led and locally owned plan for a system wide reduction in a third of all face to face outpatient consultations with alternative models of delivery or a reduction in demand
- Development of a work force plan that harnesses alternative delivery methods incorporating first line therapist interventions such as direct referral for GP's to specialist physiotherapists in gynaecology, increased utilisation of the nurse consultant and specialist nurse model as first contact practitioner and undertaking diagnostics
- Establishment of a system wide best practice model for outpatient services that utilises digitisation and other technologies to maximum effect.
- A review of clinical pathways in specific high demand services such as ophthalmology to streamline delivery, reduce unwarranted variation, improve access and improve the service user experience
- Utilisation of the estate to maximum effect relocating outpatient activity outside of the acute sector and into localities
- Develop and implement, through collaboration with our population, a system wide education and support programme that introduces new technologies and prepares users for its implementation

These aims will be achieved over a five year period, with an agreed implementation plan with support and coordination provided through the ICS structure . They will be implemented as part of place based improvement programmes.

Shorter waits for planned care - surgery

BOB Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Establishing ICS Wide Clinical Networks

Clinical Networks – The ACW will work with partners across BOB to create functional clinical networks where they do not already exist. The framework will be based on best practice exemplars such as the cardiac, vascular, ENT and spinal networks that already exist. The network will introduce high impact interventions to improve its planned services. The purpose of the creation of the networks is to provide a robust basis from which partners across BOB can work together to utilise system wide capacity to its best advantage. It is from this work that the increases in planned surgery will result following baseline analysis of demand and capacity and exposition of opportunities for redistribution of services closer to patients within their localities.

Data to support joint decision making	**Use of good quality data - we will use a wide source of data interpreted under local conditions to target resources in the areas that will achieve the greatest value such as Dr Foster Intelligence, NHS Right Care, Fingertips, Four Eyes Intelligence and GIRFT** **Robust demand and capacity reviews informing where there could be a redistribution of activity across BOB** **Use BADS guidance to inform transfer of elective in patient to day case activity** **Theatre productivity dashboards which drill down to speciality, surgeon and list level opportunities**
Operational best practice models	Implementation of waiting list management principles and use of the national elective access policy driven through improved training and supervision Implementation of 6 – 4 – 2 theatre scheduling Implement best practice models of care for preoperative assessment with a call to patients at high risk of DNA or cancellation the day before Escalation processes to avoid cancellations Explore opportunities for providers to work together to allow greater flexibility during periods of high demand
Planning care and improving productivity	Utilise Enhanced Recovery Protocols Review scope for implementation of productive ward and productive theatre principles Improving system wide theatre productivity to improve touch time, utilisation; start times, finish times, inter-case downtime, overruns
Supporting our staff	Determine and implement a best practice model of care for staffing in a theatre environment, review of rotas and skill-mix this include e rostering and job planning Explore methods of flexible and remote working Develop our staff to support new roles such as First Contact Practitioners, Consultant Pharmacists, Specialist Physiotherapists, Nurse Endoscopists and Colposcopists
Using technology as an enabler	Review the scope for increased use of digital technology and robotics within services to include wear able diagnostic devices, virtual reality and augmented reality technology (need examples)
Commissioning	Consider implementation of the Nottinghamshire Service Restriction Policy Develop a framework for the implementation of patient choice at 26 weeks

Shorter waits for planned care - surgery

BOB Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Resources Required

Assumptions have been made that the costs to support the resources below are included in 'Place' based plans, that includes IT and associated infrastructure that are accounted for within Global Digital Exemplar (GDE) funding streams.

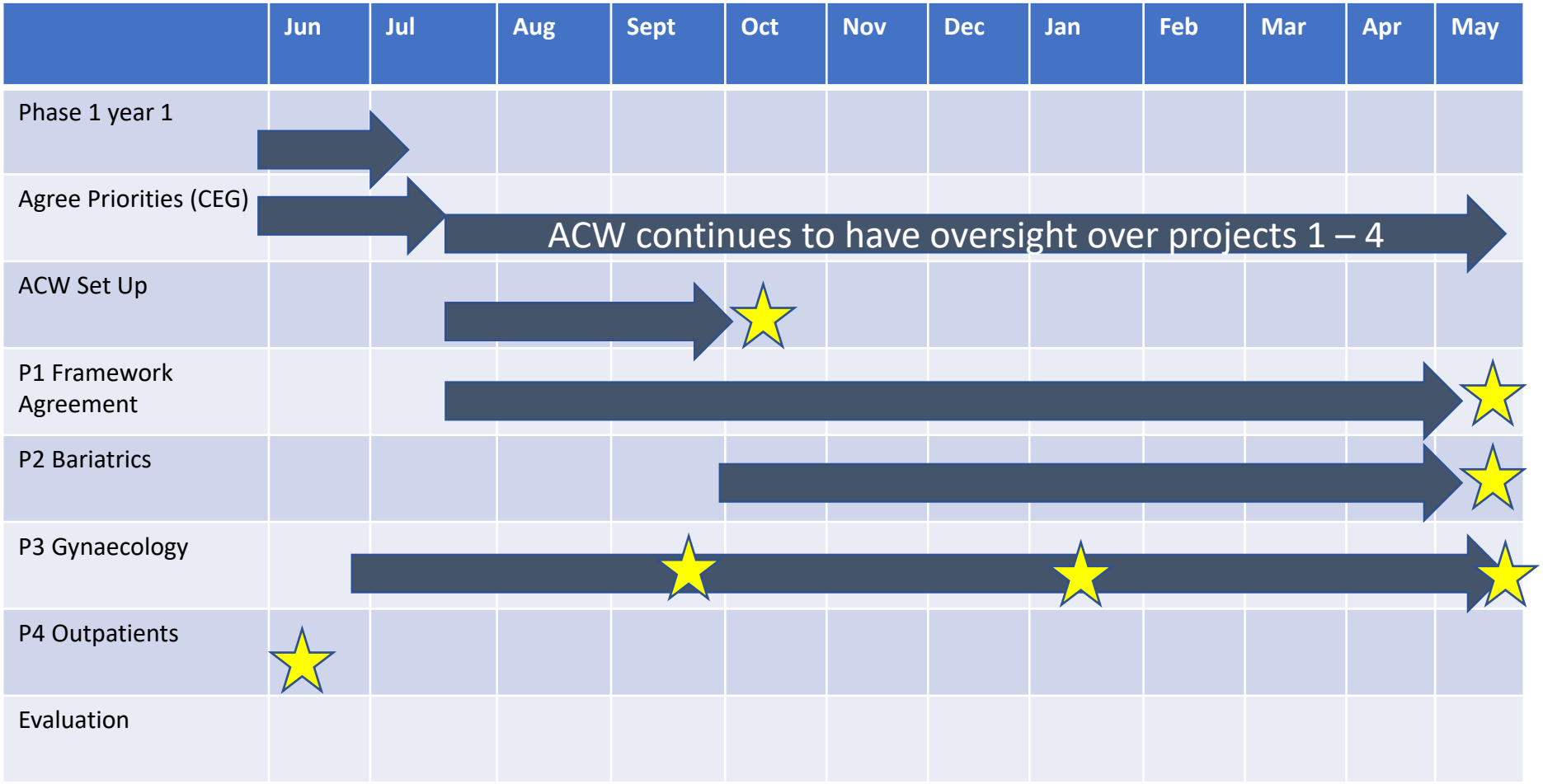
Category	Resources	Cross System Benefit	Indicative Costs
Workforce	New posts – First Contact Practitioners Costs in succession planning (including any uplifts to encourage secondments) Training and education programmes – to support patients and staff Improvement team at an ICS level to support ACW programme and support delivery of Place based improvement plans		? In Place based plans
External Support	Four Eyes Insight input to continue the work across the BOB ICS Gynaecology Network to improve productivity and efficiency		£130k
IT Infrastructure & Training	Review each place based requirement for any increased revenue required for IT platforms to support remote monitoring, self check in, clinic room booking, application development for roll out,		? Covered by GDE funding
Capital	Any requirement for refurbishment, equipment		? Covered in capital programmes
User Training	Required for any increase in the introduction of new software as specified in the objectives Any further requirement for the introduction of new technology		? Covered by GDE funding
Stakeholder Engagement	Social media (any surveys etc that we may have to pay for), telehealth (wear able diagnostic tools), virtual reality/augmented reality: VR/AR		? Covered by GDE funding
Reducing RTT waits to 26weeks	Administrative 'Choice' process support (recurrent) Project support and Informatics (Fixed term) Activity transfer: Scenario 1 – 15% - 20% 'Choice' take up (based on previous experience) Scenario 2 – 100% 'Choice' take up		£265,083 £300,188 £1.2m - 2.4m £15m

Shorter waits for planned care - surgery

BOB Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Timelines for Delivery of the BOB ICS ACW Programme for Planned Care

This Programme will continue along a 12month cycle brining in new priorities as projects are completed ensuring a continuous process of learning and improvement across a 5 year cycle



For each Project (P1 – 4) there is a set up and diagnostics phase followed by mobilisation, implementation and evaluation is undertaken periodically to stock take on impact in line with KPI's set by each project team.

Increasing focus on Population Health

BOB Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

A 'golden thread' through our plan for health and care services

Delivery of more joined up care for the populations collectively served by BOB ICS and our ICPs runs through every aspect of our plan. Population Health Management (PHM) will be integral to create a single 'source of truth', identify the priority opportunities to proactively target the right care for specific populations and shape the culture of the ICS and our three ICPs.

To support this development BOB ICS will be participating in NHS England PHM Development Programme, building on participation of Berkshire West in the wave 1 programme. This will support BOB ICS and the ICPs to build our collective capability across the system, neighbourhood and networks to make informed data-driven decisions that enable teams to act together to make best use of collective resource to achieve practical and tangible improvements in the health and wellbeing of our communities.

As a 'golden thread' through our work to improve the health and care of our populations it touches on all areas of our plan, from prevention and primary care to the treatment of long term and mental and physical health conditions.

Building on the Berkshire West PHM Development Programme

Throughout the wave 1 programme, in Berkshire West we have generated evidence of successful implementation of interventions targeted at specific groups of people and developed greater internal PHM capability in order to deliver the triple aim of improving health outcomes, improving patient experience and reducing per capita costs. We also agreed the following key areas for action:

1. Agree core PHM leadership and resource

- Ensure that the there is sufficient clinical and analytical resource from system-wide partners

2. Developing a shared care record

- Develop a clear and supported plan for delivery of connected care
- Establish clear governance for connected care to provide robust assurance and keep momentum

3. Development of Primary Care Networks

- Align development of PHM with Primary Care Networks including using new national and local funding
- Understand the skills necessary to engage with networks, clinicians and professionals

4. Governance arrangements

- Ensure structures support provider networks in integrated delivery and acknowledge the long term alignment around populations
- ensure that the structures and processes are supporting primary care networks as the units of change
- Ensure a single Information Governance process is in place to achieve the development of a single system

5. Develop system analytics capacity

- Develop understanding and application of actuarial principals at executive and Board levels
- Conduct a skills mapping exercise across the various analytics teams
- Identify suitable candidates for the role of "Analytics Champion" and evolve 'Analyst huddles' into 'Analyst Hubs' (including training)

Increasing focus on Population health

BOB Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Digital

Effective use of digital technology is a key enabler of PHM. We will focus this work on:

- Infrastructure
- The creation of platforms to support system /place analytics – building and developing tools both at Place and ICS.
- Intelligence
- Consideration for a visualising ICS analytic hub as being developed in Berkshire West ICP could be the central point for all intelligence.
- The introduction of an analytic development programme - Roll out of a development programme that links health and care professionals. transformation teams and analysts to approach issues in a different way
- The removal of duplicated and unnecessary reporting.
- Intervention
- An approach to using PHM - with new ways of working through the intelligent use of data and enhancing pathway management.

Our digital infrastructure to support PHM ranges from place-based platforms to the Thames Valley and Surrey Local Health and Care Record (TVS LCHR) partnership.

Place based PHM programmes will continue to be developed so that we can quickly identify those groups at risk of adverse health outcomes to facilitate earlier intervention. Early work has already been undertaken in Berkshire, this will be used to inform the PHM agenda across the whole of BOB and early use of the analytics capabilities such as the Connected Care platform, the HealtheIntent platform and other local intelligence platforms. The PHM programmes will close the gap for missed elements of pathways and provide greater transparency in health and social care to identify health inequalities, support future planning policies and changes to public service provision.

BOB is a founding member of the TVS LHCR partnership which will create a Thames Valley and Surrey wide data repository to be developed to share information for all TVS patients and will be particularly useful for those patients receiving cross border care and will focus on key areas initially such as maternity and cancer. LHCR will be used alongside local analytics tools, as an ICS we will agree what analytics will be undertaken locally and what would be beneficial to undertake at LHCR level.

To underpin our future work, we will develop an integrated function that will deliver PHM solutions and support at every stage of the PHM learning/commissioning cycle:

- **Understanding population and health care** (e.g. risk stratification; deep dive analytics; health economic techniques – efficiency and quality of life measures; engagement – stakeholder and service user);
- **Opportunity analysis and targeting** (e.g. risk stratification; AI and machine-based learning tools – pre-condition identification and targeting of patients to reduce financial impact and improve outcomes; actuarial analysis; service pathways reviews);
- **Predictive system Modelling** (e.g. system dynamic modelling; AI and machine-based learning; health economic methods – cost effectiveness/ forecasting model/population health costing models);
- **Design and implement interventions** (e.g. system dynamic modelling – micro and macro; knowledge management – identification of interventions which deliver outcomes/cost efficiency; health economic methods – allocative efficiency and prioritisation methods; contractual innovations e.g. outcome-based contracts);
- **Active monitoring and improvement** (e.g. evaluation frameworks; performance management frameworks; development and measurement of outcomes; bespoke reporting environments and dashboards; HE methods; training/knowledge transfer to end users).

Prevention & Addressing health inequalities

BOB Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Long Term Plan requirements

- The NHS Long Term Plan sets out new commitments for the NHS to enact to improve prevention, but recognises that the NHS cannot do this on its own, and especially recognises the key role played by local government through housing, social care, education and planning but also in the commissioning of preventative health services such as smoking cessation, drugs and alcohol services, sexual health and school and health visitors.
- The NHS needs to detect disease early, seek to prevent deterioration and reducing symptoms, improving quality of life.
- The Global Burden of Disease quantifies and ranks the contribution of risk factors that cause premature death in England. Smoking, diet, high blood pressure, obesity, alcohol , drugs use, air pollution and lack of exercise are seen as significant risk factors.

The BOB ICS picture

The BOB ICS operates in one of the most affluent areas of England achieving some of the lowest deprivation scores. Just 13.3% of the ICS population has a long-term health problem or disability, compared to a national average of 17.6%. However, BOB ICS has looked at population needs and have identified a range of health inequalities in different locations.

Case for change

The BOB ICS performs well in many lifestyle-related and healthcare metrics (such as obesity and diabetes prevalence). However, there are areas in the south of Oxford and Reading which are in the 20% most deprived parts of the country. These areas will have distinct health and care requirements that are not highlighted by BOB ICS averages. It is important that these residents are targeted in to address health inequalities, this could be done through 'neighbourhood' teams in these areas applying population health management principles and providing tailored services.

Current performance across BOB

Indicator	Bucks.	Oxon.	Berks. West	BOB STP	SE Avg.	Nat. Avg.
Lifestyle metrics						
Life expectancy (male)	81.9	81.4	80.5	81.3	80.6	79.5
Life expectancy (female)	84.9	84.6	84.3	84.6	84	83.1
Under 75 mortality rate (per 100k)	257	262	293	269	294	332
Deprivation score (IMD)	9.8	11.5	11.7	11.0	-	21.8
Travel to work by car (%)	71.0	-	70.3	-	65.8	63.0
Smoking-related metrics						
Smoking prevalence (%)	9.6	10.7	11.6	10.6	13.7	14.9
Smoking attributable mortality (per 100k)	190	188	221	208	230	263
Deaths from COPD	38.8	38.5	46.7	41.0	45.9	52.7
Under 75 preventable respiratory disease mortality rate (per 100k)	11.0	14.5	15.9	13.8	15.7	18.9
Alcohol and substance abuse related metrics						
Percentage of regular drinkers	6.5	5.7	4.6	5.6	6.2	6.2
Percentage of adults binge drinking on heaviest drinking day	14.1	19.6	17.7	17.3	15.5	16.5
Admissions from alcohol-related episodes (per 100k)	503	493	490	495	525	636
Alcohol-related mortality (per 100k)	37.9	39.0	46.0	40.7	42.5	46.2
Under 75 mortality rate from alcoholic liver disease (per 100k)	5.3	4.1	7.4	5.4	7.0	9.0
Under 75 preventable liver disease mortality rate (per 100k)	10.0	11.3	15.0	12.0	13.8	16.3
Deaths from drug misuse (per 100k)	2.3	2.5	5.6	3.3	3.9	4.3
Obesity-related metrics						
Excess weight in adults (%)	57.8	56.0	58.9	57.1	59.7	61.3
Diabetes prevalence (%)	5.9	5.0	4.9	5.3	6.0	6.7
Under 75 preventable CV disease mortality rate (per 100k)	33.1	31.6	38.6	34.1	37.0	45.9
Cancer-related metrics						
Under 75 preventable cancer mortality rate (per 100k)	63.1	61.5	72.1	65.1	71.6	78.0
Deaths from oral cancer	4.3	3.8	3.7	3.9	4.1	4.6
Deaths from lung cancer	40.2	40.6	45.2	41.8	48	56.3
Mental health-related metrics						
Under 75 (premature) mortality in adults with serious mental illness (per 100k)	1,432	1,147	1,573	1,361	-	1,429
Suicide rate (per 100k)	7.3	9.2	8.2	8.3	9.4	9.6
Other mortality rates						
Infant mortality (per 1k)	4.1	2.9	3.4	3.2	3.4	3.9
Deaths from stroke, all ages, standardised mortality ratio	87.9	94.9	95.4	92.8	-	100.0
Killed and seriously injured (KSI) casualties on England's roads (per 100k)	45.5	53.9	32.1	44.9	50.6	39.7

X Better than the national average X Similar to the national average, X Worse than the national average
RAG ratings provided by Public Health England.

Prevention & Inequalities – case for change

BOB Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

The BOB approach

A focus on prevention will see services moving towards a model embodying active population health management as a precursor to moving away from a reactive model of care. Many of the opportunities for driving this work will present at Place with the interconnectedness of organisations, including the developing Primary Care Networks. However BOB can provide a forum to share learning and knowledge and provide an assurance role.

The priorities for prevention in the ICS plan are for the benefit of the whole population, however we know that opportunities and outcomes leading to long and healthy lives are not the same for all residents. To narrow the gaps within the ICS there is a need to identify where these inequalities lie and take action.

The places where people live and work are hugely influential on their health and wellbeing; creating health promoting environments makes health choices easier and more accessible for all and not just those with time, education and resources. This will be important work for all ICS partners

There are a huge number of contacts each year within the NHS and other public services providing opportunities to promote behaviour change. Change is rarely a discrete, single event so consistent messages across the system will help. Starting with brief and simple advice makes sense because some patients will indeed change their behaviour at the directive of a health professional. This is why prevention runs through the governance, approaches and priorities for the ICS.

Targeting work to reduce unwarranted variation in opportunities and outcomes and reduce health inequalities is essential to ensure that the burden of disease in the worst off is reduced.

(Cont) The BOB Prevention Group is developing its role to support all the ICS workstreams as they plan and deliver initiatives to Prevent ill health, Reduce the need for treatment, Delay the need for care and tackle health inequalities.

Reducing health inequalities

BOB ICS aims to establish a system wide approach to identifying unwarranted variation by using agreed and consistent evidence and methodology and then seek to demonstrate continuous improvement in addressing unwarranted variation. The integrated nature of the system will mean that work will be occurring at different levels with support and knowledge flowing appropriately. To support this work we will see:

- In 2020 all PCNs will review the data working with local Public Health teams to address the inequalities.
- Improve recording of ethnicity and other protected characteristics in NHS patient records
- Adopt systematic use of Equity Audit and Equality Impact Assessments
- With topic leads for mental health, develop Business cases to access future targeted funding for:-
  - Hub and spoke models for problem gambling
  - Mental health services to support rough sleepers.
  - Enhanced suicide prevention and bereavement support services

Progress to date

The BOB Prevention Group has already delivered important work across the whole area, including driving forward training and support for Making Every Contact Count, identifying gaps in weight management services, setting out priorities for reducing Cardio vascular disease, completing a stock-take on current tobacco control measures and highlighting inequalities in outcomes in our population. Areas for future progress will include road accidents in Buckinghamshire and Oxfordshire, as well as drug misuse in West Berkshire.

Prevention & Inequalities – deliverables & activities

BOB Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Deliverables

The BOB ICS will progress its prevention work through:

- Working to ensure that prevention and the reduction of health inequalities is a core theme in the work of BOB ICS to seek to prevent illness and keep people physically and mentally well; reducing the need for treatment including through early detection; and delay the need for care, keeping people independent for longer;
- Identifying named strategic and clinical leadership for prevention and inequalities;
- Identification, intervention and referral for people who smoke and misuse alcohol;
- As large employers in our communities ICS constituent organisations will seek to improve the health and wellbeing of the workforce to improve staff satisfaction, reduce sickness, improve productivity and population health.
- BOB ICS will develop a system wide approach to reduce health inequalities through building healthy environments and communities that promote healthy behaviours.
- Health (MH) services across).

Challenges to delivery:

- A move to the provision of predictive and proactive care will require a significant change in behaviours and governance. A system wide view is felt to be beneficial for decisions as to how resources are allocated to address prevention and inequalities priorities;
- There is a need to address the causes and consequence of inequalities this will include ICS actions to create healthy environments and communities and targeting programmes and care towards those experiencing poorer health;
- The ICS and constituent organisation need to find new ways of working to improve sustainability and tackle factors such as air pollution and plastic waste.

Activities

Smoking

- There is an overarching ambition to be smoke free by 2030. There is a focus on smoking by manual workers, adults with long term mental health problems and the number of women smoking at the time of delivery.
- All Trust's are to be fully compliant with the CQUIN for screening and brief advice for smoking and alcohol in inpatient settings. Work will continue on making every contact count. All secondary care settings to comply with and enforce smoke free policies by April 2022. Trust's to provide support for temporary abstinence for smokers unready to stop completely or permanently.

Alcohol

- Reduce alcohol specific hospital admissions and readmissions for men and women by 10% from 501.1 per 100,000 (2016/17).
- All Trusts to be fully compliant with the CQUIN for Screening and Brief Advice for Smoking and Alcohol in Inpatient Settings
- Expand the capacity of Alcohol Care Teams in acute settings and expand their role to a wider range of clinical specialties.
- Making Every Contact Count in all settings to discuss

Air Pollution

BOB plans to implement the Clean Air Strategy, including 20% reduction in CO emissions from NHS travel by 2023-24, which will form part of local Sustainability plans. This will require working with local government to support the appropriate infrastructure and the use of technology to reduce the amount of travel, part of which can be seen with plans to use virtual technology to support the delivery of outpatients.

Prevention & Inequalities – deliverables & activities

BOB Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Activities (cont)

Obesity

The target is to reduce prevalence of excess weight in adults and levels of children obesity and reduce the proportion of the population currently deemed physically inactive. A number of key activities have been identified to support this work:

- Engage with people when they connect with services to discuss healthy weight and physical activity;
- Pregnant women who are overweight/obese should be offered information and advice and referred to weight management support, where it is available;
- Work with public health, schools, and health visiting teams to instil early life course for obesity;
- Engage with people when they connect with services to discuss healthy weight and physical activity.
- Pregnant people who are overweight/obese should be offered information and advice and referred to weight management support, where it is available.
- Work with public health, schools, and health visiting teams to instil early life course for obesity
- Provide Tier 3 obesity services across the patch as part of a comprehensive pathway for weight management.
- Set out local referral trajectories for National Diabetes Prevention Programme uptake and deliver them
- All hospital and healthcare settings to implement the Government Buying Standards for food and catering services (GBSF) and ensure food policies include healthy options in all outlets including vending machines.
- Increase active travel for staff, patients and local population.
- All settings to develop travel plans with supporting local activation to get staff and patients to walk and cycle.
- Increasing staff knowledge, skills and confidence to have useful and meaningful conversations about physical activity.

Anti-microbial resistance

- Implement BOB level actions to reduce anti-microbial resistance as set out in 5 year action plan
- halve healthcare associated Gram-negative blood stream infections;
- reduce the number of specific drug-resistant infections in people by 10% by 2025;
- reduce UK antimicrobial use in humans by 15% by 2024;
- reduce UK antibiotic use in food-producing animals by 25% between 2016 and 2020 and define new objectives by 2021 for 2025; and
- be able to report on the percentage of prescriptions supported by a diagnostic test or decision support tool by 2024.
- BOB will seek to optimise use, reduce the need for and unintentional exposure to antibiotics, promoting effective Antimicrobial stewardship through DIPCs, monitoring adherence to prescribing guidelines
- Places to engage with residents to increase awareness of the problem AMR presents to population health and the steps everyone can take to preserve antimicrobials.

Wider Social Impact – progress placeholder

BOB Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Context

There is clear recognition in the system and at Health and Wellbeing Board level that 'health' is impacted and influenced by a great range of factors This fact is reflected in the work of BOB ICS and the places within in terms of integrated approaches to prevention, to targeted provision in response to identified need and in the increased emphasis on *healthy place shaping*

Progress to date

There are a number of key areas of work across BOB and at place that support a joined up approach to the consideration of wider social impact including (but not limited to):

- Healthy New Town projects and local commitments to health place shaping
- Holistic population health and care needs approaches adopted by Health and Wellbeing Boards and driven forward by health and care partners in Ox and Bucks
- The work of the Oxfordshire Growth Board
- The work across BOB to support the Oxford to Cambridge ARC

Key stakeholders

System partners across health and care including community and voluntary partners are working with wider organisations and partnerships such as the Local Economic Partnerships. There are common goals and shared ambitions for BOB and place. The links and overlaps to these goals and ambitions is now resulting in shared action and delivery that includes

Draft deliverables

- A clear strategy for **Anchor Institutions** and how they can support the overall sustainability of the BOB system
- A shared approach to the **delivery of healthy place shaping –** drawing on the exemplar work of the healthy new towns
- Using a population health and care needs approach to develop **models of care designed to meet population needs** now and in the future – at the most appropriate local level
- Maximising the involvement and influence of health in the significant growth and development associated with the ARC and the growth deal – reflecting those wider social determinants of health
- Continued work with regional and national partners to ensure that the needs of veterans and armed forces and those linked to health and justice services are appropriately identified and that future service delivery models work as a collaborative part of the into the emerging integrated care teams

Next steps

Further work is underway to develop content for the final plan submission. This will begin with a workshop that will draw out specific approaches and opportunities being taken in line with Anchor Institutions – recognition of the impact that Foundation Trusts and Universities in particular can have on the environment on future employment opportunities, on the local economy and on sustainability and carbon reduction programmes.

Personalisation – the BOB ICS vision

BOB Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Vision

As an Integrated Care System we will:

Enable people to get more control over their own health and have more personalised care when they need it.

We will do this by:

- Continuing to deliver improvements in choice and personalisation through Local Maternity Systems so that by March 2021 all women have a personalised care plan. We will build on the collective 'Better Births' plans in each place delivering the recommendations.
- Moving towards people getting more control over their own health and receiving more personalised care when they need it.

Examples of this work

- Introducing social prescribing as part of Primary Care networks so that people have access to a wide range of local support services that help to keep them well and living in their communities.
- Increasingly patients will be involved in making informed decisions about their care. Expanding our approach to Making Every Contact Count. We will expand the range of long term conditions including Diabetes, COPD, asthma and cardiovascular diseases
- The ICS will increase the number of patients with complex problems and those at the end of life who have personal care plans that are developed with them and shared by all those involved in their care
- Apply the NHS Comprehensive model of personalised care using a targeted and prioritised approach for example for those living with dementia.
- The ICS will learn from the good practice demonstrated by our local authority partners and increase the number of people who have personal health budgets (PHBs). The ICS will look to develop a programme to ensure that the delivery of all new Continuing Healthcare home-based packages (excluding fast track) use the personal health budgets model as the default delivery process. We also plan to expand the PHB offer to users of wheelchairs and people entitled to S117 Aftercare. Our submitted trajectory shows an increase of X PHB's for in recognition of the baseline position and the work required.
- Having Primary Care Networks implementing the comprehensive model for personalised care, improving the management of patients for example for those with heart failure and ensuring that all high risk patients have personalised care plans.
- Digitally enabling our communities both the population and professionals who work in our system through a significant expansion in our digital capabilities and increasing use of Personal Health Records.

Maternity – background & current provision

BOB Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Background

The local maternity system was established across in March 2017in line with the Better Births Report: National Maternity Review published in June 2016. However, this development build on a history of joint working across the Thames Valley where a number of groups had been established. The BOB Local Maternity System Delivery Plan for 2017-2021 was published in February 2019.

Provider	Location	Type of Unit
Buckinghamshire Healthcare NHS Trust	Stoke Mandeville Hospital	Obstetric Unit Alongside Midwifery Unit
	Wycombe Birthing Centre	Freestanding Maternity Unit
Oxford University Hospitals NHS Foundation Trust	John Radcliffe Hospital	Obstetric Unit Alongside Midwifery Unit
	Horton General Hospital	Obstetric Unit (currently functioning as a Freestanding Maternity Unit)
	Wallingford Community Hospital	Freestanding Maternity Unit
	Wantage Community Hospital	Freestanding Maternity Unit
	Chipping Norton (Cotswold Birthing Centre)	Freestanding Maternity Unit
Royal Berkshire NHS Foundation Trust	Royal Berkshire Hospital	Obstetric Unit Alongside Midwifery Unit

Maternity Settings within BOB. BOB is able to offer all three choices for place of birth as recommended in Better Births; obstetric care, midwifery led care and home births.

Engagement

The development of the Maternity System work over recent years has been informed through engagement with stakeholders including Healthwatch and Maternity Voices Partnership. This has resulted in feedback through surveys and focus groups. BOB LMS provides funding to Maternity Voices Partnerships to ensure engagement with women and their families in the community, gathering feedback and representing women's voices at local and regional level.

Maternity – vision, aim and objectives

BOB Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Vision and aim

'Our vision for maternity services across BOB LMS is for them to become even safer, kinder, more personalised and family friendly'

Our aim is for every woman to be able to make informed decisions about her care and the care of her baby, by having access to individualised information and support throughout her maternity care experience.

To realise this, we need well-led organisations in which staff are fully supported; enabled and motivated to provide woman-centred care in collaborative teams, promoting a culture of innovation and continuous shared learning'.

Our objectives

Objective 1 - Improving Safety	• Reducing rates of stillbirth, neonatal death,maternal death and brain injury during birth • Women and their families will benefit from improved care aimed at reducing avoidable incidents
Objective 2 - Increasing Choice and Personalisation	• Every maternity service will have sufficient capacity to care for women booked for care • Women will be supported to make informed choices and receive standardised information
Objective 3 - Transforming the Workforce	• The right workforce will be available in the right setting to best provide services to women and their families
Objective 4 - Improving Access Perinatal Mental Health Service	• To support all women to be able to access local specialist perinatal mental health services and treatment when require
Objective 5 - Improving Prevention	• Offer women the opportunity to access preconception care to ensure optimal health for women and their babies

Maternity – key activities (1)

BOB Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Workforce

BOB LMS has established a workforce workstream. Each Trust has produced a report to understand midwifery workforce requirements.

Digital

BOB LMS has established a digital workstream which will look at ensuring women have a maternity digital hand held record by 2023/2024. BOB ICS is well placed on digital maturity with a number of providers having been given Global Digital Exemplar or Fast Follower status. The provider Trusts have undertaken a high level gap analysis of digital system requirements for maternity services. In RBH the Cerner millennium maternity module will be fully implemented by October 2020. The information system will provide women with digital access to records and RBFT staff a paper light digital maternity information system in community and hospital settings.

Implementing Better Births

Governance arrangements are in place to continue to oversee the delivery of this work and there are Better Birth Midwives in the Trusts to meet on a monthly basis to implement recommendations and have a particular focus on Personalisation and choice; continuity of carer and implementation of personalised care plans.

Personalised care plan

Each maternity service across the BOB LMSis unclear whether women feel they are receiving personalised care planning, however there is an ambition that by March 2021 all women receive personalised care plans. In May 2018 a TVSCN personalisation and choice workshop was held. Subsequently BOB LMS commissioned Healthwatch to undertake a survey and focus group which saw 1664 people respond to the survey. BOB LMS have decided to commission the Mum & Baby app, for three years, to support the standardisation of personalised care plan for women.

Maternal medicine network

BOB ICS has been included in the proposed Maternal Medicine Networked to be established across the Thames Valley which aims to align to the safety workstream to improve outcomes for mothers and babies.

Continuity of carer

This work is being implemented in different ways across the 3 places. Buckinghamshire are looking to roll this out to different cohorts of women in a sequential manner including aiming to implement CoC for women booked under midwifery led care by the end of January 2020, for women under the perinatal mental health team categorised as medium and high risk by the spring 2020.

In Oxfordshire the current CoC rate prior to changes sat at 8% and this will rise through a series of targeted developments through to 14% in 19/20, 28% in 20/21 and 51% in 21/22.

In Berkshire at the end of August CoC achievement was 16%. There are plans in place to supplement the existing team with another team to work in an area of Reading with a diverse population and high ethnic minority commencing in January 2020.

Saving Babies Lives care bundle version two

Each trust across BOB LMS has undertaking gap analysis of saving babies lives care bundle version 2 with the compliance being RAG rated to understand the gaps.

Maternity – key activities (2)

BOB Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Continue to improve safety

- 50% reductions in stillbirth, maternal mortality, neonatal mortality and serious brain injury by 2025.
- Healthcare safety investigation (HSIB).
- Maternity incentive scheme – reward delivery of 10 key maternity safety actions.

BOB are looking to improve safety through a range of approaches including:

- Continuing to standardise clinical guidelines across BOB which has included guidelines for preterm birth (updated in 2019), IUGR , cervical cerclage (2018), placental investigation (2016), palliative care (2017);
- Oxford AHSN PSC has established the Regional Perinatal Governance group for BOB+TV & Frimley, facilitating bespoke training with the Patient Safety Academy on Human Factors and System Analysis for incident investigation for the group (over 30 staff trained) in 2019. The Oxford AHSN PSC have developed BOB wide and TV package for intra partum fetal monitoring (CTG) together with a teaching package;
- HEE funded the development of an e-learning training and assessment package on the use of an intelligent approach to intermittent auscultation of the fetal heart during labour for midwifery and obstetric staff. Received national recognition from Each Baby Counts & British Journal of Midwifery. The PSC/AHSN are project managing the development of this package of work to be integrated into a national platform with HEE;
- Conducted formal qualitative assessments, in collaboration with the Patient Safety Academy, through a process of interviewing staff across the BOB & TV maternity services on the barriers to following regional guidelines, currently undergoing thematic analysis and will be published later this year. The findings will be used to drive improvements in the implementation and adoption of regionally agreed guidelines;

Cont.

- Based on 2015/16 and 2016/17 MBRRACE data RBFT had achieved a 10.3% reduction in stabilised and adjusted perinatal mortality rate;
- RBFT are members of the National Maternal and Neonatal Safety Collaborative, with two projects working to improve outcomes.
  1. Reducing avoidable term admission to neonatal intensive care due to neonatal hypoglycaemia: To date unwarranted variation has been addressed and reduced in relation to thermal care of the new born, assessment of neonatal risk and completion of feeding assessments.
  2. Reducing Fetal Hypoxia: Reliable processes for fetal risk assessments have been implemented in all intrapartum areas. The project is currently focusing on reducing variation in the Fresh Eyes process.

Maternity – key activities (3)

BOB Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Perinatal mental health

The development of the Perinatal workforce continues as each specialist service attends the Perinatal MH Simulation training days in September and October 2019. There is an educational study day for specialist perinatal teams in November to also develop the workforce.

The new BOB LMS mum and baby app also supports mothers emotional health and wellbeing.

RBFT have a perinatal mental health clinic and hold multi-disciplinary case review meetings to ensure women receive joint care that is appropriate personalised to them. RBFT hold a weekly Birth Reflections Clinic which women self-refer to.

OUH have maternity outreach clinics with obstetric & psychiatric input both at the John Radcliffe and at Horton Hospital. Future developments include:

- Plans to develop psychological pathways to address PTSD/Tocophobia & Birth Trauma (collaborative input between psychology, maternity & MH) in 2021/22.
- Maternity led Services to address multi morbidity & social complexities. This will include joined up pathways between MH services & substance misuse (collaborative approach).
- Community Hubs to further expand the maternity outreach clinics – to include joint postnatal reviews. This will also incorporate care needs & signposting to meet the needs of fathers in 2022/2023

Infant Feeding

BOB LMS have committed to use part of their maternity transformation funding to improve the breastfeeding provision both in the unit & community, but also a real focus within the proposed transitional care end of the postnatal ward.

Access to postnatal physiotherapy

RBFT have a dedicated obstetric physiotherapy team. Any women sustaining obstetric anal sphincter injury at birth are now routinely reviewed in a dedicated postnatal clinic run by gynaecologist / obstetric consultant. In 20/21 RBH will review feasibility of physiotherapy education class for women, and review expansion of postnatal physiotherapy service. At BHT there is a perineal clinic and are reviewing the service model to include physiotherapy.

Children & Young People (CYP) – introduction

BOB Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Background

The workstream developing this content is continuing to formalise and will be supported by the BOB ICS to pull together multiagency leadership from across all three places. The workstream will then agree how implementation of the LTP can be delivered at either place level or ICS level. Costed plans will then be developed (business cases). At this stage, this section is still in draft and awaiting further information and development. A workstream workshop will take place in early October to continue this work.

BOB ICS has existing workstreams that include priorities for Children and Young People. There are interdependencies for the children's workstream with the following workstreams / sections of this draft submission:

- Maternity
- Mental Health
- Autism
- Personalisation
- Cancer

Aactivities will focus on addressing key risks to delivery:

- Workforce
- Aligned funding

BOB ICS vision for CYP

BOB ICS recognises that children are rightly a major priority in the Long Term Plan. BOB ICS has been developing a dedicated Children and Young people's standalone workstream to meet these requirements. National and local learning suggests that systems re-design and continued improvement benefits most from having partnership Systems Leaders jointly committed to system transformation. Engaging Directors of Children's Services, Police leaders and education leaders is particularly important, and leaders from the third sector.

The national Children and Young People's Transformation Programme was established in April 2019 and aims to support delivery of the commitments in the LTP as follows:

- Improving outcomes for children with SEND and autism
- Expanding mental health services for Children and Young People
- Reduce hospital admissions by providing joined up care
- Improvements for long term conditions such as asthma, diabetes and epilepsy
- Improved cancer outcomes and experience

Children & Young People – current provision

BOB Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

At a BOB level the CYP population growth plateaus in the mid-2020s as it is expected that the birth rate will decline. However, the area is subject to a great deal of new development and an anticipated influx into the area so growth is expected, we have been seeing increasing acuity and complexity in CYP presentations and would expect this to continue.

Buckinghamshire

In Buckinghamshire there are 134,000 children aged 0-19 years (2017 ONS Mid-year Population Estimates), which is 25% of the total Buckinghamshire population. The child population aged 0-19 is projected to grow to 145,300 (25.2% of the Buckinghamshire population) by 2027. This is a higher proportion of the population as a whole when compared to both the South East (23.8%) and England (23.8%)

Buckinghamshire has much better educational attainment than the national average, a highly skilled workforce and lower levels of poverty and unemployment. Buckinghamshire is ranked as one of the least deprived counties in England.

Buckinghamshire has a number of pockets of significant deprivation, with some areas in Aylesbury Vale falling into the second most deprived decile (2015 Indices of Multiple Deprivation). This can have a significant and lasting impact on children. For example:

- Children living in the most deprived areas of Buckinghamshire are more likely to be underweight at birth and die in the first year of life than those living in the least deprived areas.
- At the end of the first year of primary school, 41% of those living in the most deprived areas have a good level of overall development, compared to 69% in the least disadvantaged areas.
- Children and young people from more disadvantaged areas have higher admission rates to hospital for a range of conditions including chest infections and asthma, injuries, self-harm and substance misuse.
- There is a strong link between levels of deprivation and the likelihood of children having contact with Children's Social Care. Local analysis indicates that children in deprived areas are 2.5 times more likely to be on a child protection plan than the Buckinghamshire average.

Oxfordshire

There are 154,000 children aged 0-18 years living in Oxfordshire. This population is predicted to rise by up to 10% over the next decade. The majority of indicators of child health show Oxfordshire as statistically better than the national average. Oxfordshire benchmarks well for children in terms of both the NHS Atlas of Variation and NHS Rightcare. Measures for the wider determinants of health highlight six specific groups for who health, education and social care outcomes are worse than their peers. These are:

- Children who have Special Educational Needs and Disability
- Autistic children
- Children from black and minority ethnic communities
- Looked After Children (and those on the edge of care)
- Young People known to Youth Justice Services

Health services for children in Oxfordshire cover a wide range of primary and community services, acute and specialist services.

Berkshire West

Information to follow in final submission.

BOB ICS has a range of services including:

- General paediatrics (with sub-specialties)
- Open access CAMHS (and local inpatient provision)
- Comprehensive universal services through health visiting and school health nursing.
- Primary care
- Paediatric A&E
- Integrated therapy teams (Speech and Language OT and physio)
- Children community nursing and complex care teams
- Vulnerable children's nursing team
- End of life nursing team and local Specialist Children's Hospice.

Children & Young People – LTP expectations

BOB Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Expectations of the Long Term Plan

Children & Young People's access

- Over the next 10 years: 100% of CYP who need it will be able to access specialist mental health (MH) services
- At least an additional 345,000 CYP aged 0-25 will be able to access support via NHS MH series by 2023/24
- Extend current service model to create a comprehensive offer for 0-25 year olds that reaches across MH services for CYP and adults.

Standards

- Test four week waiting times pilot in services with view to establish a national waiting time standard for CYP
- Boost investment in CYP eating disorders services to allow us to maintain delivery of the 95% standard beyond 20/21.

Schools and Colleges

- Mental Health Support Teams working in colleges—rolled out to 1/4 of the country by the end of 2023

Crisis care and care of the vulnerable

- All CYP experiencing crisis will be able to access crisis care 24 hours a day, seven days a week by 2023/24
- Commitment to improve outcomes for vulnerable CYP—improving access to targeted support, especially through transition

Community Mental Health

- New services for children who have complex needs that are not currently being met, including for up to 6,000 highly vulnerable children with complex trauma. These services will provide consultation, assessment, treatment and transition into integrated services

Learning Disabilities and Autism

- Over the next three years, autism diagnosis will be included alongside work with CYP MH services to test and implement the most effective ways to reduce waiting times for specialist services.
- Action will be taken to tackle the causes of morbidity and preventable deaths in people with LD and Autism. Improve uptake of the existing annual health check in primary care for people aged over 14 years with a learning disability, so that at least 75% of those eligible have a health check each year.
- ICSs will be expected to make sure all local healthcare providers are making reasonable adjustments to support people with a learning disability or autism. Over the next five years, national learning disability improvement standards will be implemented and will apply to all services funded by the NHS.
- For children and young people, no more than 12 to 15 children with a learning disability, autism or both per million, will be cared for in an inpatient facility.
- By 2023/24, all care commissioned by the NHS will need to meet the Learning Disability Improvement Standards.

Physical Health of CYP

- From 2019/20 clinical networks will be rolled out to ensure we improve the quality of care for children with long-term conditions such as asthma, epilepsy and diabetes.
- Selectively moving to a 0-25 years' service will improve children's experience of care, outcomes and continuity of care.
- childhood immunisation to reach at least the base levelstandards in the NHS public health function agreement.

Cancer

- From 2019, we will begin to offer all children with cancer whole genome sequencing to enable more comprehensive and precise diagnosis, and access to more personalised treatments.

CYP – current & planned activities

BOB Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Current and planned activities

- The LAC Health Team provides statutory health assessments for children who are looked after, recognizing that the health and wellbeing outcomes for this group of children are poorer than across the children and young people population as a whole
- The local CAMHS service provides a specific pathways for children who are looked after and children and has a current priority to widen access by reviewing the needs of groups who are historically under-represented in the service, including some BME groups
- In line with a Local Transformation Plan significantly improve access to emotional wellbeing and mental health support by reducing waiting times and strengthening pathways for our most vulnerable children. This will ensure that 34% children and young people with a diagnosable mental health condition will receive treatment from an NHS-funded community mental health service.
- In one place set up three Mental Health support teams in 2020 that will increase capacity to both identify and intervene earlier as well as strengthen the knowledge and response of local schools, one team in each LA area. These teams will contribute another 1000 interventions a year when fully operational as well as provide highly valuable training and consultation to local school leaders in order to get children, young
- develop the current community eating disorder service and ensure that the service is compliant against NICE standards and will meet national standards on access and waiting times for children
- Work is underway across the STP footprint to develop a bid for an all age Intensive Support Service. This is due to report late 2019/early 2020.
- Work is underway to increase the number of people aged 14 years+ who register on the GP Learning Disabilities registers and then access a Learning Disability health check.
- There is a need to ensure sufficient capacity and resource to reduce the number of out of area placements (OAPS). Whilst BHFT have been able to achieve their target trajectory, the position remains volatile. The ICP have invested in a Bed Management Team and will review opportunities for the use of alternative provision including crisis beds and "safe haven" models. NHSE capital funding will enable a 12 bedded unit for General Adolescent Services, including specialist eating disorder services to open in the summer of 2020, which should reduce OAPs and support young people closer to home.
- The ICP has a specific focus on children and young people in ED and CAMHs in individual organisations, as well as the use of SAFE improvement programmes– recognising that reducing avoidable harm reduces bed days and delivers more efficient care.
- In one place work is underway looking to develop age appropriate crisis review services to support children and young people being successfully managed without requiring an admission.
- Wave 1 Trailblazer funding secured to deliver mental health support teams in schools. Two multi-agency teams (including staff from the Youth Service, Family Support Service and Voluntary Sector) are now running, providing support to 32 Buckinghamshire Schools.
- Kooth online counselling commissioned and embedded to widen opportunities to access mental health support
- All age Eating Disorder pathway implemented with further work underway to streamline referral and assessment processes.
- Learning Disability CAMHs are working with the Adult Learning Disability Health provider to develop services for the 14 -25 age group who present with the highest level of risk. This will include the creation of a Dynamic Risk Register and Intensive Support Team that straddles Oxford Health and HPFT, providing intensive support using a Positive Behaviour Support (PBS) framework. This service will be designed to prevent inpatient admissions where possible, strengthen in county placements and reduce the use of out of county placements

CYP – current & planned activities

BOB Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Current and planned activities

- The LAC Health Team provides statutory health assessments for children who are looked after, recognizing that the health and wellbeing outcomes for this group of children are poorer than across the children and young people population as a whole
- From September 2019, all boys aged 12 and 13 will be offered vaccination against HPV-related diseases, such as oral, throat and anal cancer.
- Over the next five years, paediatric critical care and surgical services will evolve to meet the changing needs of patients, ensuring that children and young people are able to access high quality services as close to home as possible
- From September 2019, all boys aged 12 and 13 will be offered vaccination against HPV-related diseases, such as oral, throat and anal cancer.
- Over the next five years, paediatric critical care and surgical services will evolve to meet the changing needs of patients, ensuring that children and young people are able to access high quality services as close to home as possible
- Personalised care and involvement of children, young people and families
- NHS services that keep children well, including though digital technology
- Improve transition to adult services and move to a 0-25 service
- Improving uptake of immunisations and reducing child mortality.

- The case for change in children's services is compelling: Children's health and the way children live have changed rapidly over the last decade. More children are living with long-term conditions and children are surviving into adulthood with life limiting conditions. More children are identified as having special educational needs and disability (SEND). More children have complex comorbidities and are experiencing mental health problems.
- More children are living in families where domestic abuse, mental health and substance misuse impact adversely on their health outcomes and life chances (Adverse Childhood Experiences ACEs)

- Work is underway looking to develop age appropriate crisis review services to support children and young people being successfully managed without requiring an admission.
- In order to meet these ambitions, Thames Valley and Wessex Strategic Clinical Networks have co-designed a Systems Leadership training programme, expected to reach over 5000 members of the local workforce, including senior systems leaders, to support a more coherent ICS approach to systems change pan-CCG and LA boundaries. The training embeds our best practice from our strongest areas who have made the greatest improvements to CYP mental health i.e. a restorative model of 'high challenge and high support'. It provides an explicit set of tools to help senior leaders to problem solve tricky systems issues, these same skills help frontline staff to work more effectively together to improve mental health outcomes for children – this is underpinned by a common set of values i.e. local leaders determining how they want to work together. The explicit aims of the training are to help us to meet the ambitious aims for CYP mental health transformation, this includes being an effective tool to help schools prepare for Mental Health Support Team (MHST) investment and the benefits for helping STPs/ICSs to work more together as mature systems are starting to be recognised.
- This project also trains children and young people, in a restorative approach to support mental health system co-production, to ensure that their experience informs mental health system improvement. Whilst the programme is focussed on the children's mental health agenda, the strategic benefits for the physical health agenda are equally relevant.

Learning disabilities & Autism - introduction

BOB Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

How this submission is structured - NHS Improvement Standards

Over the next five years, national learning disability improvement standards will be implemented and will apply to all services funded by the NHS. These standards will promote greater consistency, addressing themes such as rights, the workforce, specialist care and working more effectively with people and their families. As part of developing these improvement standards, NHS Improvement identified some services that provide care to people with learning disabilities, autism or both, and others that provide care only to those with learning disabilities.

The improvement standards are used to frame the structure of this submission, aligned to Transforming Care and Building the Right Support, the outgoing plan. This submission is a summary of more detailed plans. The standards and improvement measures can be used as metric both within Trusts and across BOB to monitor improvement against the plan commitments.

Standard 1: Respecting and protecting rights: Adjusted pathways, access and equality of outcomes/ Identification and Flagging/ Death investigation & learning/ Restriction monitoring & anti discriminatory practice

Standard 2: Inclusion and engagement: engagement, values led, codesign, learning complaints, investigations, mortality reviews and family engagement, empower people and families to exercise their rights.

Standard 3: Workforce: specialist knowledge and skills, updated, mitigation plans for specialists, clinical & practice leadership

Standard 4: Specialist Learning Disability Services: Community based intensive support, CETR/ CTR, Medication (STOMP/ STAMP), Inpatient, Restrictive Practice governance and alternative approaches

Prevalence

Learning disability refers to a significant general impairment in intellectual functioning that is acquired during childhood. Approximately one in 50 people in England have learning disabilities, 908,000 adults had learning disabilities, of whom 21% were known to learning disability services. Autism is a lifelong, developmental disability that affects how a person communicates with and relates to other people, and how they experience the world around them. There are around 700,000 people on the autism spectrum in the UK – that's more than 1 in 100.

Learning disabilities - BOB in figures

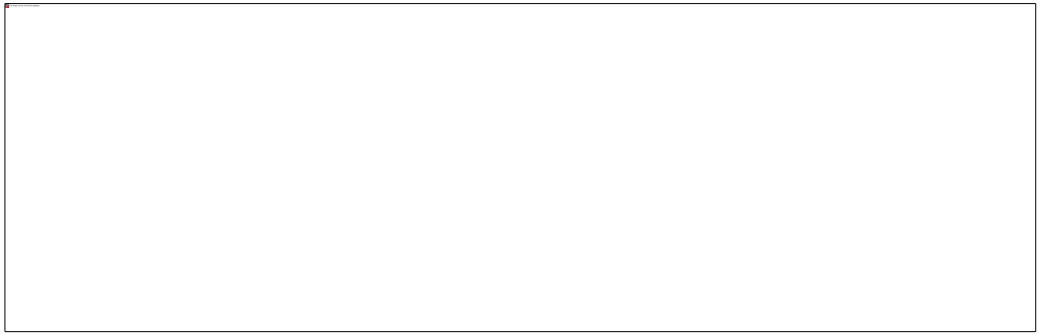
Adults: Registered Patients with a LD 2018/19 (based on 2017/18 population)

- Buckinghamshire 2198
- Oxfordshire 2765
- Berkshire West 2183

Increase in 65+, ageing starts earlier (45/50+)

According to research (Emerson and Baines in 2010), around a third of people who have learning disabilities also have autism.

Forecast increases in numbers with Learning Disability and Autism Spectrum Disorder, BOB ICS footprint



Learning disabilities & Autism – introduction

BOB Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Autism – BOB ICS in figures

Oxfordshire Children's Needs Analysis (Oxfordshire County Council, 2015) estimated a 1% prevalence rate for autism which equates to 1,500 children and young people. The Oxfordshire Autism Joint Commissioning Strategy 2013-17 estimated there were around 6,850 adults on the autistic spectru (based on a prevalence level of 1%). Total approximate autistic population= 8,850.

West Berkshire, Wokingham and Reading autistic population has been estimated using a 1.3% ratio to the general population due to the high numbers of IT employment opportunities in the area, influencing where autistic people may locate. Total approximate autistic population= 5,282

Buckinghamshire's estimated number of children on the autism spectrum is approximate 1,390 and for adults around 4,169. Total approximate autistic population= 5,559.

Using these estimation the total estimate of autistic people (all age within the BOB ICS is 19,691.

While autism is not a mental health condition, it is estimated that 71% of people with autism also have mental health difficulties. Based on the estimated population across BOB 13,980 autistic people with a co morbid mental health condition. Research into this area is still developing, but a recent academic paper found that 12% of a group of people experiencing homelessness showed strong signs of autism (Churchard et al., 2017).

Autism – what people have told us (examples):

- 'We would like support from clinicians that understand autism'
- 'When people make reasonable adjustments for me, it makes a real difference'.
- Families would like more support to coordinate care, across the system in a family centered way.
- Care closer to home.
- Access to autism specialist that we know well and they know us.
- We have to wait too long for assessment of autism, and when we get it there is no support.
- To have to tell my story once. (ie tell people there reasonable adjustments or diagnosis and all health systems to be aware of this)

Autism - what people said needs to change (examples):

- Shorter waiting times for assessment of autism
- More support post diagnostic, in particular with social skills, and emotional literacy skills.
- Access to specialist support for autism needs (PDA profiles, catatonia, gender dysphoria, relationships) when they need it.
- Support to coordinate care
- Health checks for autistic people.
- Better access for people with autism on probation e.g. day services.
- Sensory integration all age, sensory pathway work
- Better support within schools for children and young people on the spectrum.
- More support with benefits, housing and employment.

Learning disabilities – Standard 1

BOB Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Respecting and Protecting Rights LD - Adjusted pathways, access and equality of outcomes/ Identification and Flagging/ Death investigation & learning/ Restriction monitoring & anti discriminatory practice

Where are we now

People with learning disabilities (PWLD) are known to experience access issues and poor outcomes relating to health which can lead to premature, often preventable death. On average, adults with a learning disability die 16 years earlier than the general population – 13 years for men, 20 years for women.

Gaps, unmet need, inequalities & unwarranted variation

- Health checks are lower than place based targets and do not meet the Long Term Plan trajectory
- Outcomes of health checks are not understood /not having impact
- Health passports (including hospital passports) are used but not consistently in adults and do not include children.
- Unwarranted variation in acute liaison in numbers of staff, services covered which is leading to negative experiences
- Digital flags are not consistently in place so we do not know if a person with LD is accessing service
- LeDeR notification percentages of conversion to reviews are markedly different across BOB

Deliverables

1. People with learning disabilities will have the same access to health care that everyone else has and enjoy better health as a result of increased uptake of an annual health checks to 75% in primary care and well managed medication where this is needed (STAMP-STOMP programme).
2. Where people with learning disabilities have died, their deaths will be reviewed within 6 months (LeDeR death review process) and any themes will be used to improve health including e.g. preventative screening and implementation of reasonable adjustments to facilitate equity of access to all NHS services.

Outcomes

1: Digital flags are in place for everyone, all age, LD and autism to enable tracking and reasonable adjustments to be understood and made.

2: 75% + of young people 14+ and adults take up an annual health checks (proportion on GP LD register), the results of which are converted to a Health Action Plan including access to public health initiatives (screening, smoking cessation), hospital passports and clearly understood outcomes, which leads to better health.

3: People with learning disabilities access reasonably adjusted Mental Health pathways (as evidenced by year on year improving scores on the Green Light Toolkit) and physical health pathways.

4: Where someone with a learning disability has died, this is reviewed within six months and learning is used in each place and across BOB to address health inequalities.

Learning disabilities – Standard 2

Inclusion and engagement LD - Engagement, values led, codesign, learning complaints, investigations, mortality reviews and family engagement, empower people and families to exercise their rights

Where are we now

There is a wide variety of inclusion and engagement inconsistently in place across BOB, including some good practice e.g. joint chairing of TCP by those with lived experience, quality checkers, families involvement in mortality reviews and complaints, coproduction of solutions to place based issues. The long Term Plan commitment states that systems should involve people with lived experience and their families in checking the quality of care, support and treatment.

Gaps, unmet need, inequalities & unwarranted variation

- Quality checkers not been system wide mobilized across Oxon; Bucks and Berkshire West across all provisions.
- There is a need for a quality assurance framework that is system wide to gather stats from across BOB in regards to involvement in recruitment/ projects development / service feedback e.g. *I Want Great Care*.
- Employment statistics are included in NHSI reports but only for health employers as the standards pertain to trusts. One person employed in Bucks plus paid engagement / OHFT paid engagement. Link to workforce needed.

Deliverables & Outcomes

1: Systems involve people with lived experience and their families in checking the quality of care, support and treatment including high uptake of questionnaires for the annual benchmark of NHSI Improvement provider standards across BOB and the checking of reasonable adjustments for people with learning disabilities, autism or both when they need it.
Activity: BOB wide user led audit and (tbc) mystery shopper

2: People with learning disabilities and autistic people are part of the workforce
Activity: Ensure this is included in LD specific place based plan, LD BOB plan and ICS plan, to include internships audit across BOB, joint work with employment services in local authority

Learning disabilities – Standard 3

BOB Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Workforce LD - Specialist knowledge and skills, updated, mitigation plans for specialists, clinical & practice leadership

Where are we now

Risks identified are: retention including upskilling the current and future TCP workforce; Recruitment – adopting different approaches, addressing the impact of Brexit and the weaker pound:

- Children's and Young People's Workforce, particularly the development of workforce planning in these services
- Training of the wider NHS and social care workforce in LD and Autism issues. National consultation results awaited.
- Integration of Health and Social Care – particularly an issue in Berkshire, as two different models of care are being adopted by the two ICS (Frimley and BOB)
- Engagement with providers - availability of housing and support packages & market shaping(underway across BOB);
- Funding for training – particularly to enhance standards across providers and provide basic training - Funding from NHSE has been received in September 2019 to further develop these plans and mobilise training in PBS and autism.

Gaps, unmet need, inequalities & unwarranted variation

- Significant gaps in knowledge resulting in inequalities of access, particularly stark for autistic people
- Informal carers needs need to be reflected e.g. support they need such as advice and information, hands on help, training, participation and short breaks including in emergencies
- Emerging need for specific specialism around growing older (meeting NICE guidance) with a focus on dementia, due to increase in population 65+ - place based
- ICP/ BOB wide need for further specialisms for small numbers of people with very complex additional mental health presentations including PD who are frequent users of the whole system

Deliverable

Ensure workforce challenges specific to the LD workforce (e.g. the challenges in learning disability nursing) are reflected in the wider workforce programme, that positive behaviour support is rolled out & awareness of the need to facilitate access to care is understood across all services.

Outcomes

1 : Improve the quality of care for people all age with LD and / or autism and behaviours that challenge across the Berkshire, Oxfordshire and Buckinghamshire (BOB) ICS
Activity: Workforce Development - a coproduced LD, PBS and autism training programme including minimum standards and qualifications that can be passported between providers/ Implement a programme of training for commissioners and providers and improve the understanding of the needs of people with learning disabilities and autistic people

2: Work towards a full and vibrant system wide all age workforce.
Activity: Ensure workforce challenges specific to the LD workforce (e.g. the RNLD challenges) are reflected in the wider workforce programme, that awareness of the need to facilitate access to care is understood across all services and training aligned to community support e.g. positive behaviour support is rolled out

Learning disabilities – Standard 4

BOB Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Specialist Learning Disability Services - Community based intensive support, CETR/ CTR, Medication (STOMP/ STAMP) and Inpatient, Restrictive Practice governance and alternative approaches

Where are we now

Progress against the Transforming Care national model 'Building the Right Support' is significant across BOB. Community specialist health services are delivered by three Trusts across BOB, ATU specialist beds BHT Campion, for Bucks provided by HPFT Herts, Forensic in patients provided across the NHS and independent sector and FIND team by OHFT. Place based forensic support being agreed currently to compliment FIND team.

- **Community based intensive support** – All areas have undertaken reviews to learn from admissions and inform their community planning to prevent inappropriate admissions
- **Care Education Treatment Review/ Care and Treatment Reviews** – System wide acknowledgement that these are hard to sustain and the quality is variable
- **Medication (STOMP/ STAMP):** Sign up to the pledge /use of the programme tools to understand and reduce medication is not underway in some **di**areas within BOB (some STAMP/ STOMP in Oxon/ Bucks).
- **Inpatient (mental health)**: All three places are currently just within the "NHSE planning assumptions" for inpatient admissions which gives a combined LD and autism figure per million population (autism more complex to predict and likely to inflate figures).
- **Inpatient forensic: Currently this pathway is not part of NCM, where NCM has OHFT as lead provider across Thames Valley and Wesses. Variation of providers and not working closely as is in place for NCM MH**
- **Restrictive Practice governance and alternative approaches:** Restriction monitoring in place but no BOB wide understanding or governance

Gaps, unmet need, inequalities & unwarranted variation

- STOMP-STAMP has not been rolled out consistently across BOB and therefore CYP and adults could be subject to overmedication.
- Unwarranted variation in CTR/ CETR across BOB
- Community based IST varies across the BOB in terms of capacity, age range and is contextual / place dependent - on social care commissioned provision in each place;
- Unwarranted variation to support crisis and prevent admission
- Oxfordshire has no local specialist provision and commissions out of area beds of variable quality and resulting impact on length of stay, user and family experience (model codesigned) to ensure quality and reduced lengths of stay
- Ensure these services/ this cohort aligned to New Care Models and ongoing FIND/ place based forensic team.

Deliverables

1. People with complex needs, health, education & social care will work together to support them to live and stay well in the community with the right care and support, rather than getting support in hospital (wherever possible, supporting in crisis and to prevent crisis).

2. Learning Disability, Mental Health, social care & the third sector will work together to tackle unwarranted variation in intensive, crisis and forensic community provision and capacity to provide consistent alternatives to admission including personal health budgets and make best use of beds available within BOB where needed to reduce reliance on specialist beds, especially those out of area

Learning disabilities – Standard 4 (cont.)

BOB Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Specialist Learning Disability Services - Community based intensive support, CETR/ CTR, Medication (STOMP/ STAMP) and Inpatient, Restrictive Practice governance and alternative approaches

Outcomes

1: People with of all ages with learning disabilities will not experience overmedication Activity: All sign the STOMP pledge, complete regular audit; engage with a de-prescribing programme where indicated and an LD Prescribing consultant across BOB to support moving forward along with CCG medication optimization and management colleagues.

2: People with learning disabilities have access to intensive and crisis support when they need it, including beds in ordinary Activity: ensure the community intensive and crisis offer across BOB meets needs and can evidence their impact; number of beds in place and across BOB strategically

3: People have appropriate housing and support within the community which helps them live well, particularly for those of all age who present with complexities and are most at risk of admission. Activity: Improved collaboration between health, education & social care to ensure more proactive & preventative community support & care for those with complex needs Aligned adult inpatient provision across BOB, reducing reliance on specialist beds especially Out of Area Placements by tackling unwarranted variation in intensive, crisis and forensic community provision and capacity. This will require collaboration between LD, Mental Health, social care & the third sector to provide alternatives to admission and personal health budgets. Use the NHSE funded market development to address the challenges of sourcing cost-effective providers of supported accommodation who have the necessary values, approach, skills and experience to support people with a learning disability or autism or both who have the most complex and challenging needs including those stepping down from forensic services.

4: CETR/ CTR 12 point discharge planning is sustainably available for all of those that need or request it Activity: Commissioners across both health and social care (plus secondary commissioners/ NCM leads where relevant: OHFT) join up to agree administration, process.

5: The opportunities afforded by the FIND team, enhancing of the community forensic teams and NCM is realized in shorter lengths of stay for people with learning disabilities. Activity: Consider the FIND team being funded from the NCM work more long term.

Autism – Standard 1

BOB Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Respecting and protecting rights AUTISM: Adjusted pathways, access and equality of outcomes/ Identification and Flagging/ Death investigation & learning/ anti discriminatory practice

Background

National and international research evidence tells us that Autistic people are more likely than the general population to experience elevated rates of co-occurring mental health conditions (Croen et al. 2015; Howlin and Magiati 2017) and elevated rate of co-occurring physical health conditions compared to the general population (Cashin et al. 2018) but we don't know enough about what autistic people do or don't access or the outcomes they experience as a result. As the standards are equally applicable to PWLD including autistic people with a learning disability, a natural comparator to draw is against the standards and autistic people with a learning disability.

Where are we now

Diagnostic pathways - Age thresholds for diagnostic services vary across BOB with pediatrics and specialist trusts diagnosing children at varying ages. All services have seen an increase in referrals for assessment of autism, doubling in the last couple years. The majority of people referred for autism received a diagnosis (between 66%-90%) – a clear sign of rising demand.

Buckinghamshire: 73% of referrals are from primary care. 66% of the total number of patients that received an assessment in 18/19 were diagnosed with Autism. Bucks bids to NHSE to reduce waits. Joint work with BHT who are the diagnostic service for children under 11. . These services have a backlog as well as new referrals. Linked to EHCP process.

Kingwood diagnostic service for adults in Oxfordshire received 681 referrals for an autism diagnostic assessment in the first year of the contract July 18-June 19 including a backlog of 246 that were handed over from the previous contract providers waiting list. They are currently averaging 36 referrals per month, with most aged 18-25.

Berks west: Adult diagnosis, there were 240 referrals, of which around 45% get a full diagnosis of autism and around 45% get diagnosed with having some of the traits and were on the spectrum. Around 10% of referrals do not have traits or a diagnosis of autism For children and young people, referrals increased by 17% between 2015/16 and 2016/17 and were 6% higher again by the end of Q3 this year. We anticipate that this increase will be well over 10% once triage is completed.

Health pathways - In primary care, Health checks are not in place specifically for this population (unless they have co-occurring learning disability). There is some proactive support to primary care e.g. 70 GP champions Oxon, Bucks are training GPs. In Community Health there are some adjustment examples (e.g. sensory boxes and video in EMU Oxon) but more is needed to understand and support the rest of the community workforce, especially school nurses (given CYP are being excluded/ self exclude)/ link to CAMHs workers in schools.

Specialist Mental Health for adults is provided by two Trusts (OHFT & BHT). Use of the Green Light Toolkit as an audit to check if services are reasonably adjusted and improve access (for both pwld and autistic people) is not applied consistently across BOB. Given Autistic people are more likely to experience poor mental health, 70% of autistic individuals have one mental health disorder such as anxiety or depression, and 40% have at least two mental health problems, data trawls within OHFT across Oxon and Bucks do not reflect these numbers, only 144 were open to community mental health services (70% of 2,278 is 1594/ 40% of 2,278 is 911)where CRIS data analysis reveals autistic people had more/ longer appointments that a comparator group ; although IAPT data is not available (there is no local or national code/ clinicians petitioning for this).

Autism – Standard 1 (cont.)

BOB Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Respecting and protecting rights AUTISM: Adjusted pathways, access and equality of outcomes/ Identification and Flagging/ Death investigation & learning/ anti discriminatory practice

Where we are now (cont.)

Identification and flagging – beyond coding within primary care (currently not pulled together as a register) and diagnostic codes, identification and flagging of autistic people is piecemeal and minimal across BOB . There is limited if any data to be able to support Vohra et al. although SCAS and EDPS data has been requested.

Death investigation and learning – autistic people are not included in Leder Cohort, place based vulnerable adult mortality reviewing systems do not include autistic people, so there is no learning from deaths that can support the development of pathways. However, research evidence indicates that mortality rates are as of much concern

Gaps, unmet need, inequalities & unwarranted variation

There is no standard approach regarding flagging or identifying autistic people using services across the BOB footprint. There needs to be further training for staff regarding the importance of flagging and identifying autistic people and obligation under the equality act. Within each BOB area, there are a number of IT barriers in regards to sharing information regarding reasonable adjustments and access needs.

Diagnosis waits are extensive across BOB. Some diagnostic pathways are not NICE compliant for best practice (MDT approach to diagnostics). More data and consideration is needed regarding gender and diagnosis (although Oxon is half and half) and unwarranted variation regarding diagnosis across neurodevelopmental categories is needed as this varies. Assessments are being sourced privately across BOB.

Primary Care Health checks are not being completed for autistic people currently so this would be a new endeavor for GP's/ primary care and the starting percentage (without LD) would be 0%.

(cont.) There are issues with service contracts excluding Autism (ie Mental health and SLT). Inequalities in comparison to people with LD/ autistic people with LD are not favorable either in terms of autistic people not enjoying the benefits of technologies used to support pwld but also that autistic pwld experience mortality rates.

LeDeR process des not include autistic people so we cannot identify those dying and learn from this in the same way we do for pwld. There are no autism leads currently in place to take forward learning around autism to ensure quality and learning when incidents occur, so very limited opportunity to fulfil the LTP commitment of tackling the causes of morbidity and preventable deaths for autistic people.

Gaps for forensic services: PBS, sensory rooms and equipment, SALT, women's LD and ASD pathway across the network, asd champions, LDFCMI and T (asd patients), ward based asd training, good awareness on wards other than specialist, enough trained staff to complete sensory and ASD assessments (1 psychiatrist trained only), ados and adri tools for assessment needed, recruitment, male/ female diagnosis, dorset have no forensic community team to pick up, ASD post diagnostic support.

Reasonable adjustment around PHSE programme/ school nursing ; TDA teachers biggest workforce for autism

SEND data could be used – EHCP plans – health elements, to help plan
Online resources for users, interventions NHS APP, local offer, quality assured, database standardized

Autism – Standard 2

Inclusion and engagement Autism - Engagement, values led, codesign, learning complaints, investigations, mortality reviews and family engagement, empower people and families to exercise their rights

Where we are now

Inclusion and engagement is inconsistent across BOB, Autism partnership Boards (Think Autism) are in place but not all active, an active Community Engagement Group in Bucks system wide and a health Autism Experience Group for adults in Oxon. Currently:

- There are charities across BOB that are supporting parents, carers and autistic people, however often over scribed. There are parent forums that are actively working with commissioners in Oxfordshire (OFSN and Oxfordshire Carer's forum)
- Strategies and service information is not always in an accessible format.

Gaps, unmet need, inequalities & unwarranted variation

- There is limited engagement with autistic people across the BOB in a formal capacity to inform service delivery. 'Quality checkers' is a specific Learning Disabilities initiative that could be rolled out to include autistic people.
- There is a need for a quality assurance framework that is system wide to gather stats from across BOB in regards to involvement in recruitment/ projects development / service feedback e.g. *I Want Great Care.*
- Employment statistics are included in NHSI reports but only for health employers as the standards pertain to trusts. The number is not known.

Deliverables

1: Systems involve people with lived experience and their families in checking the quality of care, support and treatment including high uptake of questionnaires for the annual benchmark of NHSI Improvement provider standards across BOB and the checking of reasonable adjustments for people with learning disabilities, autism or both when they need it.
Activity: BOB wide user led audit ? Mystery shoppers?

2: People with learning disabilities and autistic people are part of the workforce
Activity: Ensure this is included in LD specific place based plan, LD BOB plan and ICS plan, to include internships audit across BOB, joint work with employment services in local authority.

Autism – Standard 3

BOB Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Workforce Autism- Specialist knowledge and skills, updated, mitigation plans for specialists, clinical & practice leadership

Where we are now

Health and care staff, and staff in organisations with public facing responsibilities, who provide general support to autistic adults have appropriate knowledge of the condition: Oxon current: Autism Oxford multi agency training, OHFT/ Autism Oxford Tier One training video, OHFT In house training provided to teams on request by MH Liaison Nurse and delivering Autism awareness training into the NAT's training programme 1/2 day. Bucks current: GP training, IAPT team provide some adhoc training to community mental health teams

Health and care staff, and staff in organisations with public facing responsibilities, who have a direct impact on, and make decisions about , the lives of autistic adults have appropriate specialist knowledge of the condition: Oxon current: Conferences/ Master module being written.

The Long Term Plan commitment is for the whole NHS to improve its understanding of the needs of people with learning disabilities and autism, and work together to improve their health and wellbeing. Following a consultation on the options for delivering awareness training, NHS staff will receive information and training on supporting people with a learning disability and/ or autism (national consultation results awaited.

An all age LD and autism BOB wide plan including local place based action plans have been drawn up in 2019. These TCP action plans are based on mitigating the workforce risks including the ccapacity of Transforming Care Partnerships to undertake workforce planning. Additional refresher to the plan will be needed to include any national consultation results and the gaps as identified below with the underpinning principle that consistency of staff is critical.

Gaps, unmet need, inequalities & unwarranted variation

- Significant gaps in knowledge resulting in inequalities of access, particularly stark for autistic people and there is no dedicated profession (there is no autism nurse qualification for example unlike LD, MH, children's and adults) which would enable specialist support and advocate for reasonable adjustments
- There are currently no specialisms within the workforce structure. Need to consider deployment of people with skills that are applicable such as the OT workforce and how they are deployed e.g. in OHFT they are used as generic case coordinators.
- There is no clinical & practice leadership within the BOB that has direct links to national platforms to share and enhance specialist practice.
- No leadership to influence change in discriminatory practice against autistic people.
- Informal carers needs need to be reflected e.g. support they need such as advice and information, hands on help, training, participation and short breaks including in emergencies, literature shows education and supporting parents improves outcomes/ coupled with Open access family support, low level and into adulthood.
- Workforce Training – NATs, need an equivalent in social work; additional functional training such as sensory processing for the workforce would be helpful
- Greater mentoring and befriending is required.

Autism – Standard 4

BOB Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Specialist Learning Disability Services that may be appropriate for Autistic people - Community based intensive support, CETR/ CTR, Medication (STOMP/ STAMP) and (next slide) Inpatient, Restrictive Practice governance and alternative approaches

Where we are now

Community based intensive support – There is limited specialism/ or intensive support/ behavioral approach for autistic people, when experiencing a meltdown or a shutdown due to their autism. These often are misdiagnosed as a MH need and incorrect treatment/ approach taken including inpatient and medication (AMHPs not autism trained). Crisis/ quick response for older people living or supported by parents is needed. Post diagnostic support is short term and therefore not preventative. Support to live well/ psychological support e.g. trauma informed reasonably adjusted evidence based therapy / aligned with social care (Think Autism: Domain Three: Health, Care & Well-being). Evidence of voice activated systems such as alexa / apps to help structure day, webinar instead of face to face; social care analysis?

Care Education Treatment Review / Care and Treatment Reviews – C(E)TR's are still being embedded across the BOB footprint, however number have increased, but not to the national target/s timescales required.

Medication (STOMP/ STAMP) - There is currently no specialist autism leadership in place to oversee the STOMP/STAMP programmed across all age and over the BOB footprint. The Long Term Plan commitment is for the STOMP-STAMP programmes to be expanded to stop the overmedication of people with a learning disability, autism or both.

Gaps, unmet need, inequalities & unwarranted variation

- There is limited / no access to specialist to support alternative approaches to care which in turn may reduce the use of restrictive practices. By March 2023/24, inpatient provision will need to be reduced to less than half of 2015 levels, however there is currently no specialist infrastructure in terms of health and social care providers to support often complex and challenging needs in the community. Currently TC trajectories are not being met due to adults with autism being added to the inpatient numbers (being diagnosed in inpatient settings.

- There is a known use of health inpatient services to support CYP in crisis when community solutions needed/ prevent crisis – IST model from LD could be considered.

- Emerging 'within profile' areas of need are emerging e.g. catatonia, PDA, co-occurrence with e.g. ADHD, Eating disorder, intersectionality & LGBGTQIA, major functional concerns such as sleep and a case is being made for an across BOB gender dysphoria pathway (based on the forensic model).

- STOMP/ STAMP roll out is in its infancy across BOB.

- Need engagement with the independent and voluntary sector both for provision but also to provide support to live well e.g. Guidepost – mates and dates – support to young people in relationships.

- Use technology isn't fully understood or mobilized e.g. wearable devices to monitor health and early signs of ill health and living well / or social prescribing

Better Care for major health conditions (MHCs)

BOB Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Background

Each of the Integrated Care Partnerships (ICPs) within the BOB ICS have developed plans for tackling the incidence and impact of Long Term Conditions (LTCs) in place.

Plans to date and specifically those that have focussed on **Cardiovascular Disease, Stroke, Diabetes, Respiratory Disease and Obesity** include prevention, identification of those patients at high risk of developing LTCs and optimal management, all underpinned by empowerment of patients through supported self-care. The National Programmes in disease categories such as Diabetes are long established and are realising benefits.

Those local plans are supported through a close collaboration with the Hampshire and Thames Valley Strategic Clinical Network (HTVSCN) who drive Long Term Conditions plans at scale, sharing learning and best practice and act as a catalyst for change across multiple organisations internal and external to BOB such as Public Health England, Academic Health Science Networks, other ICS's and industry.

To date there is no BOB ICS wide strategic plan for LTCs and this will be a priority for development in year one of the overarching five year plan in order to provide unification of planning, reducing duplication, optimising outcomes and cost effectiveness of services offered.

BOB ICS Vision for LTCs

Bringing the place-based and strategic clinical network plans together provides a whole ICS vision for LTCs across BOB of:

'An inspired, informed and confident population who are motivated to make life choices that have positive impacts on health and wellbeing and aim to reduce the incidence, prevalence of LTCs and impact of living with one.'

Key Deliverables

We will use population health data available to better understand 'need' to inform planning assumptions for our patients with Long Term Conditions (LTCs) with a particular focus on Cardiovascular Disease, Stroke, Diabetes and Respiratory Disease. We will improve prevention and detection pre disease for all patients and not only those patients at high risk of developing LTCs through increased uptake of existing screening programmes and rapid uptake and involvement in development of new and innovative screening e.g. through links with the ICS genomics hub.

We will review and streamline pathways to remove some of the artificial barriers between primary, secondary, mental health and community care so that services and support is wrapped around the patient. We will provide a programme of education and training across all LTCs that supports professionals and patients involvement in development of new models of care that will include:

- Prevention – A key pillar of the ICS LTCs programme including primary interventions (preventing the illness) secondary (reducing the impact) or tertiary (delaying the impact).
- Personalised care – We will personalise care for the individual and their families to provide care closer to their homes and support them with digital tools and education to empower patients to better manage their conditions. We have a strong foundation on which to build rolling out work undertaken in Diabetes
- Integrated Care – linking care and access to care records across primary care, primary care networks , secondary and tertiary care and the broader ICS where care for patients with LTCs crosses boundaries particularly where there are multiple comorbidities to be managed
- Digitisation of pathway elements
- Improved awareness of health and well being - people with LTCs are more at risk of depression and anxiety
- Streamlining of the whole disease pathway that enables timely care and shortens waiting times for planned aspects of care.

Better Care for major health conditions (MHCs)

BOB Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

What we know

Based on national statistics it is estimated that there are in excess of 450,000 people (total population 1.8 million) in BOB living with a LTC.

The impact of the demand on the ICS resources is significant with an estimated 58% of all Emergency Department attendances, 70% of days spent in hospital beds, 64% of hospital outpatient attendances, 50% of all GP appointments, 59% of practice nurse appointments consumed through support of BOB clients living with a LTC

The cost of LTCs is approximated to be 70% of the total BOB hospital and primary care budget. The costs increase dramatically in those patients with multiple comorbidities, specifically those individuals with between 2 – 4 chronic conditions. Empirical evidence demonstrates that those patients with multi comorbidities have markedly poor quality of life and poorer clinical outcomes. As many as 50% of the total patients with chronic conditions also suffer from mental issues so provision of services to support this aspect of care is also taken into consideration with the BOB LTCs planning.

Those patients with LTCs and multimorbidity (comorbidity is the norm) are a clear driver of activity and cost across the ICS footprint which is at variance with peers. The geographical variation in the multimorbid population may have previously led to a more fragmented approach. Plans for the ICS will involve putting a framework in place which enables localities to take into account likely demographic and development changes and would provide standardisation and a degree of local control.

Benchmarking across BOB and with peer CCGs demonstrates that there are variations in practice and opportunities for improved detection and prevention. These will be address in BOB's programmes of care for LTCs

	Prevention and Detection – BOB ICS NHS Right Care Source data 2017/ 18
5,687	Fewer reported cases to estimated of hypertension
5,262	Fewer reported cases to estimated of CHD
1,262	Fewer reported cases to estimated of AF
9,006	Fewer reported cases of diabetes
5,967	Fewer reported cases to estimated of COPD
	Primary Care
465	Fewer at risk patients with AF receiving anti coagulation therapy
3,998	Fewer patients diagnosed with diabetes taking up a retinal scan
2,655	Fewer patients with respiratory disease being offered flu vaccine

The following slides demonstrate the work on LTCs that is ongoing and in the process of being developed across place and ICS.

Better Care for MHCs - Cardiovascular

BOB Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Ambition for Cardiovascular Disease Across BOB

TO IMPROVE THE CARDIOVASCULAR HEALTH ACROSS THE BOB POPULATION BY EARLIER DETECTION AND BETTER MANAGEMENT

Facts

- CVD is largely preventable through lifestyle changes and early detection
- Early detection & treatment of undetected atrial fibrillation, hypertension & hypercholesterolaemia will help people live longer healthier and more independent lives

Opportunity & Action

Hypertension: Panacea for CVD and risk of stroke. There is wide variation of detection and treatment between GP practices: 502,500 people undiagnosed with hypertension & 124,400 people with hypertension not treated to the 150/90 standard across TVW

Atrial Fibrillation: Increases the risk of stroke by 500% and 75% of those who do have a stroke suffer a severe stroke or fatality. There is under detection of AF by 44,900 people & 17,700 individuals are not anticoagulated and there is wide variation between GP practices across TVW

High cholesterol: is estimated to account for 7.1% of deaths and 3.7% of disability-adjusted life years in England. Familial Hypercholesterolaemia(FH) affects approximately between 1 in 250 to 1 in 500 people in the UK, approx. 130,000 to 260,000 people, including children. If undiagnosed and untreated, about 50% of men & 30% of women with FH will develop coronary heart disease by the time they are 55

NHS Health Check- Up to 80% of events could be avoided through improved prevention of risk factors. Uptake on NHS Health Check offers an opportunity for people in midlife to assess their risk of CVD and make lifestyle changes that can prevent and delay the onset of CVD. For every 6 to 10 NHS health checks 1 person is identified as being at high-risk of CVD

Heart Failure, its causes and cardiac rehab: Early detection of heart failure and heart valve disease will improve prevalence and optimise care and reduce admissions. Provision of heart failure lounge services, syncope units and expansion of cardiac rehabilitation will optimise pathways and reduce the number of cardiac arrests.

IMPACT: Increasing detection and treating of CVD will reduce the incidence of stroke, heart failure and help people live longer and healthier lives.

HOW: Focus on system wide programme of CVD prevention, detection and coding with subsequent optimum treatment. There will be an emphasis on reducing the variation in GP practice. Work ongoing will continue, for example: In Oxfordshire the Integrated Cardiology Service (ICS) model in operation in the North of the county - community cardiology clinics run by GP Cardiologists, a Pilot of 'Activate Your Heart' - web-based cardiac rehabilitation, a Heart Failure pathway review underway

Case Study: A Collaborative programme across BW, working with the Oxford AHSN to improve detection and management of people with AF, reducing the number of AF related strokes. Development of AF Champions in primary care through a bespoke approach working alongside specialist consultant. And aligned to the Prescribing Quality Scheme. Individual practices undertaking quality improvement detection projects, to identify people in primary care through the use of technology. Overall aim to avoid 11 strokes in 2019/20, rising up to 40 in 2020/21. initial feedback from cohort 1 is positive from both GPs and patients

Better Care for MHCs - Stroke

BOB Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

TO IMPROVE THE MANAGEMENT OF STROKE ACROSS THE BOB POPULATION

Facts

- Stroke is the fourth single leading cause of death in the UK and the single largest cause of complex disability
- The risk of stroke increases for people with hypertension and atrial fibrillation (AF) and it is therefore essential that hypertension and AF is better detected, diagnosed and treated.

One incidence of stroke is estimated to cost £30k for the health economy: impact on acute care, short/long-term support, loss of earnings, social care

Opportunity & Action

Hypertension and Atrial Fibrillation: Panacea for CVD and stroke risk. There is wide variation of detection and treatment between GP practices

Thrombectomy: Mechanical thrombectomy can significantly reduce the severity of disability caused by a stroke. Supporting continued improvement to timeliness of thrombectomy pathway, and provision of a 24/7 service will be a focus within HTV

Integrated Stroke Delivery Networks: To support system leadership in implementing best practice stroke pathways including pre-hospital, acute care and Enhanced Supported Discharge to be delivered to all people who have a stroke. This means a reduction in the number of stroke-receiving units to crease centralised hyper acute stroke centres to increase the number of patients receiving high-quality specialist care.

Post hospital stroke rehabilitation: provision for personalised, goal-oriented stroke rehabilitation to improve the quality of lives of all stroke survivors, enable reductions in hospital admissions and offer appropriate support

I**dentification of the capital investment** required to support stroke initiatives

IMPACT: Increasing detection and treatment of CVD will reduce the incidence of stroke and help people live longer and healthier lives.

How: Continue to work on reducing variations in practice across BOB
Establish robust clinical leadership to further develop the ISDN and contribute to forward planning that capitalises on funding streams available for stroke services.

Better Care for MHCs - Diabetes

BOB Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Ambition for Diabetes Across BOB

TO IMPROVE THE HEALTH OF THOSE WITH DIABETES ACROSS BOB BY EARLIER DETECTION & BETTER MANAGEMENT

Facts

- 3 in 5 cases of type 2 diabetes is preventable through life style changes & once diagnosed is modifiable
- 80% of the health costs of diabetes is on treating preventable complications
- People with diabetes are 5 times more likely to need dialysis or renal replacement therapy
- People with diabetes are 20 times more likely to have a limb amputation

Opportunity & Action

Continue to build on the work undertaken in the following areas: Development of shared health records and population health management tools, support for those with Diabetes & Mental Health, structured education programmes, implementation of the National Diabetic Inpatient Audit and development of treatment targets supporting management of diabetic foot disease through improving access to a (MDFT diabetes foot care team)**,** care and support planning to aid self-management with links to the personalisation agenda for empowering patients to self care as far as possible, delivering better integrated models/services of care for diabetes

Increase the use of digital tools to support self-management; Increasing uptake of structured education and wider support through provision via digital mediums. We will have a particular focus on those patients in hard to reach groups

Reducing Practice variation: significant variation in diagnosis rate, achieving NICE recommendations which effects complication rates (as above) and patient outcomes. Specifically address areas of deprivation.

HOW: A network focus on the bottom decile practices will effect improved care & reduce complications.

- **Amputations**: Variation in identification and treatment and providing consistency in the foot care pathway across BOB and ensuring access to an MDFT. Thames Valley *TV ranges 1.3 per thousand to 2.7 per thousand (*lowest UK rate is 0.6 per thousand). Opportunity for a HTV resource for system wide quality improvement to reduce amputation rate
- **Diabetic nephropathy:** Early identification and treatment reduces progression to renal failure. Example: renal replacement treatment for Oxfordshire CCG is > £11m PA (2013 prices Diabetes Case for Change 2017). Education & support across primary care networks and targeted work with the poorest performing practices in renal care

Case Study - Implementation of the National Diabetes Prevention Programme (NDPP) in Oxfordshire - Rollout of the programme has been a great success in Oxfordshire with over 4,000 referrals being made since it began two years ago. Due to the success NHSE have commissioned it for a further 3 years. A new digital option for those who do not want to attend the face to face sessions is being introduced and includes: an initial assessment, a dietitian led, personalised behaviour change programme for people with non-diabetic hyperglycaemia, delivered one-to-one over 9 months, a remote app and learning materials available 24/7, supportive materials, coaching and coach led signposting to local supportive services aims to help service users improve their confidence in self-management and achieve their weight loss, physical activity and health goals. The face to face element will include understanding diabetes, a balanced lifestyle, getting active, healthy diets, along with how to overcome obstacles and mental well-being. The sessions run regularly every 2 weeks up to week 9 and then monthly.

Better Care for MHCs – Respiratory disease

BOB Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Ambition for Respiratory Disease Across BOB

TO IMPROVE THE CARE AND MANAGEMENT OF THOSE WITH RESPIRATORY DISEASE, SPECIFICALLY COPD

Facts

- The UK is in the top 20 developed countries for COPD deaths & admissions
- COPD is the 1/3 most common cause of death in England with approximately 30,000 deaths PA
- The UK is currently one of the worst performing developed countries ranked 35 out of 37 for asthma deaths in the 5-34 year age range
- The mortality rate for respiratory disease of the most deprived deciles is increasing whist it is reducing for the least deprived
- 10-30% of people with COPD are not diagnosed until they are admitted to hospital with an exacerbation
- Only 13% of eligible people with COPD are referred to pulmonary rehabilitation (PR) services. PR improves patient outcomes and quality of life in 90% of people who complete a programme

Opportunity and Action

Improve diagnosis in primary care: 1/3 COPD cases are first diagnosed on 1st emergency admission and 1/5 on subsequent admissions. We plan to proactively identify the undiagnosed cases of COPD using primary care databases (with a key focus on deprived wards) and support screening and accurate diagnostic spirometry to allow effective management of patients (incl vaccination uptake and POC testing) which will reduce admissions and improve quality of life. A consistent model of screening and diagnostic spirometry is in the process of being developed with staff trained to required ARTP accreditation.

Frequent ED attenders will be case managed with robust care bundles and admission avoidance pathways

Pulmonary rehabilitation Access to Pulmonary Rehabilitation will improve health outcomes, avoid deterioration & exacerbations. Variation in provision is wide and insufficient. Tailoring the approach and providing digital options to suit the patient population is also required and will help improve access and retention

Medicines optimisation: A Network approach to identifying which patients need expert medication review and mobilisation of pharmacists in PCNs with a focus on addressing unmet learning needs of primary care teams will improve patients experience, their health and reduction in cost to the NHS

Palliative and end of life care: Breathlessness is a leading cause of distress and urgent care interventions, particularly at end of life. A Network approach, working with local end of life programmes, to support the introduction of timely end of life care for relevant patients is required.

Specialist support in the community: Providing acute and community support into primary care to aid diagnosis e.g. through spirometry, medicines optimisation and complex case management.

Case Study: Oxfordshire pilot of a multi-disciplinary Integrated Respiratory Team (IRT) in Oxford City and the North of the county

The IRT aims to improve the care of patients in Oxfordshire through earlier identification of respiratory disease, such as COPD and asthma, enhancing holistic and end of life care and providing extra focus on people at risk of emergency hospital admissions. The new integrated team enhances existing community, hospital-based and primary care by providing a consultant to work in the community alongside additional respiratory nurses and physiotherapists working with respiratory GPs, a dedicated psychologist, a pharmacist, dedicated smoke-free advisor and a specialist in palliative care support. The pilot started in Jan 2019 and is due to finish at the end of March 2020.

Better Care for MHCs - Obesity

BOB Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Ambition for Tackling Obesity Across BOB

TO IMPROVE THE CARE AND MANAGEMENT OF THOSE WITH OBESITY

Facts

- Commissioning of the Obesity Pathway (Tiers 1 – 4) was devolved to CCG's in BOB from Specialist Commissioning in 2016 with activity poorly defined
- The numbers of patients requiring obesity management is growing with no additional funding to support increased activity – national estimate 15% growth (2017/18 – 19) with 29% of adults classed as obese
- Current Tiers are commissioned individually and by different commissioners across BOB
- Limited funding for Tiers 2 and 3 increasing the risk of more patients requiring Tier 4 at a later date
- Unknown waiting list for Tier 4 bariatric surgery
- National media presented Tier 4 as being something that should be invested in rather than targeted reduction
- Current levels of growth of Tier 4 is unsustainable (it has grown year on year)
- Finances for Tier 4 continue to be challenged by CCG Directors of Finance as it is still unknown as to the level of risk CCGs are exposed to.

Opportunity and Action

Focussed Project to Address Compliance with the National Service Specification: An ICS project has been launched to develop a pan system obesity service that delivers best practice and provides equality of access for patients. A pan system model of care will be adopted that will provide opportunities to Improve coordination of patients between pathways – building on the work undertaken in Bucks and Berks W , single management of all services for improved integration and seamless care, clear criteria of thresholds for ongoing care that encourages better self-management by patients, ability to step up and down between pathways, improved support following Tier 4 intervention, investment in Tiers 2 and 3 to improve prevention and tier 4 appropriately, improved access to Tier 4 for patients that need it

- Undertake a gap analysis against the national high impact interventions in childhood obesity and understand where progress can be made to close the gaps
- A focus on prevention avoiding the requirement of Tier 4 surgery through public health programmes that address:
  - Childhood Obesity – raising awareness in schools
  - Improving health and wellbeing through employee based programmes.

How: A focussed project on obesity services across the ICS as part of the Acute Collaboration Work stream

Better Care for MHCs – resources required

BOB Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Priorities and Estimated timelines

	Action - High Level Five Year Plan for Delivery of the BOB ICS Plan for Long Term Conditions
Year 1	Call to system leads for LTCs to engage in building a strategy for a system wide approach Identify key stakeholders and the forum for development and implementation of a system wide plan – including patient and carer groups Undertake a gap analysis against the QOF for LTCs and ensure that whole system plans are ready to take full advantage of funding streams to support LTCs over the next five years Compare plans and draw out common themes as priorities across a 5 year programme Agree governance and accountability for delivery through the BOB ICS structure Draw together plan (incorporating all major LTC disease categories) for submission and sign off Continue to provide support to the ongoing place based plans The value added of a whole system approach will be in the systems ability to plan ahead to offer services equitably across BOB and capitalising on efficiencies as a result of improved planning for the following: **Cardiovascular Disease -** Implement the CVD prevent audit from March 2020. Developing the national accreditation and national audit programmes for cardiac rehabilitation with support to act on results and improve service quality by end of 2020/ 21, implement the PCN service specifications for CVD prevention for April 2021, continue to work with voluntary sector partners, such as the British Heart Foundation and the Stroke Association and others, employers, local authorities, community pharmacists and GP practices to provide opportunities for the public to check on their health, through readily accessible tests of high-risk conditions. There will be a particular focus on people from deprived and disadvantaged groups. Expand access to genetic testing for familial hypercholesterolaemia through the new Genomic Medicine Service. Work with NHS Providers to encourage local NHS staff to sign up to the GoodSAM App, or other means by which ambulance services can identify their location when an out-of-hospital cardiac arrest occurs. Linking with work to develop and test apps and digital technologies to support self-care and self-management pathways, including artificial intelligence (AI), ensuring the health inequalities gap is not increased as a consequence. **Stroke -** Plans to integrate Early Supported Discharge into community services, Targeted funding to support roll out of ISDNs , available from 2021/22; Targeted funding for developing and testing improved post-hospital rehabilitation models available 2020/21 and 2021/22. Fair shares funding will be available for wider roll out from 2022/23. The ICS plans will identify proposed capital investment to reconfigure stroke services via the ICS capital bids process. From 2020 onwards the national stroke team will develop and roll out: A digital approach to improving stroke pre-hospital pathways and communication, a revised payment structure for stroke services, ensuring financial levers are appropriate for, and further incentivise, integrated provision within ISDNs **Diabetes** - Providing access for those living with Type 2 diabetes to the national HeLP Diabetes online self-management platform, which will commence phased roll out in 2019/20; Ensure universal coverage of multidisciplinary foot care teams (MDFTs) and diabetes inpatient specialist nurses (DISN) teams, for those who require support in secondary care, forward planning to take advantage of the funding opportunities for control devices, roll out the HeLP diabetes platform, providing full coverage by 2021/22 draw ing on additional support from the national diabetes team via their regional diabetes programme teams.
Year 2 – 5	The plans developed in Year 1 will be phased through years 2 – 5 building on the work already in progress such as the implementation of the National Diabetes Programme, the detail of the work programme will be determined out of the priorities

Better Care for MHCs – resources required

BOB Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Resources required to support delivery of LTC benefits

Category	Resources	Cross System Benefit	Indicative Costs
Workforce	New posts Resource to support providers in progress plans as they lack project management/transformation management capacity Staff time to deliver training and education for staff and patients - - Mental health training for diabetes healthcare professionals - see Diabetes UK report New posts or re-directed posts to focus on population health management, single point of access triage, daily coordination and management across integrated team e.g. through virtual wards. Costs in succession planning (including any uplifts to encourage secondments etc)		? In Place based plans
Genomics Hub	Genomics Hub support Screening programmes Training and education – exercise classes		
IT Infrastructure & Training	Review each place based requirement for any increased revenue Need consistent and expert IT management advice to get the right digital products for LTCs . CSU Digital Transformation LHCR Team should be able to provide resource and cost requirements for implementation of shared record and population health management systems		? Covered by GDE funding
Capital	Any requirement for refurbishment, equipment		? Covered in capital programmes
User Training	Required for any increase in the introduction of new software as specified in the objectives Any further requirement for the introduction of new technology		? Covered by GDE funding
Stakeholder Engagement	Social media (any surveys etc that we may have to pay for), telehealth (wear able diagnostic tools), virtual reality/augmented reality: VR/AR		? Covered by GDE funding

Genomics – Long Term Plan context

BOB Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

"Patients with cancer or a rare disease should have access to genomics-based care, and health and care professionals should consider this as a standard part of their approach."

'Generation Genome' Annual Report of the Chief Medical Officer 2016; an independent report for the Department of Health and Social Care.

The use of genomics in clinical medicine was the subject of the Chief Medical Officer's 2016 annual report and has been highlighted as one of the key areas for targeted investment in the NHS's Long Term Plan. The NHS will be the first national healthcare system in the world to offer whole genome sequencing as part of routine care through a new national genomic medicine service scheduled for launch in late 2019. Genomic technologies are applicable across a broad range of clinical specialties, underpinning personalised medicine, enabling precise diagnoses, disease prevention, and informing prognosis and treatment, as well as generating valuable data for research.

The transformation of healthcare services needed for the routine integration of genomic testing is an ambitious undertaking but is a key aim of the long term plan nonetheless. Meeting this challenge will necessitate extensive collaboration with clinical organisations locally, regionally, and nationally, existing networks such as integrated care systems, cancer alliances and AHSNs, laboratories and pathology services, workforce development initiatives, and other stakeholders including patient groups.

The legacy of the 100,000 Genomes Project

The new genomic medicine service builds on the foundations of the 100,000 Genomes Project which sequenced the whole genomes of around 80,000 NHS patients with rare inherited disease and their relatives and patients with cancer between 2015 and 2019. This project was delivered nationally by NHS England in partnership with Genomics England, and at local level by 13 NHS Genomic Medicine Centres, each working with local trusts as designated local delivery partners. Locally over 5,000 individuals joined the project through the Oxford Genomic Medicine Centre which covers a total population of 3 million including Buckinghamshire, Berkshire and Oxfordshire.

A national Genomic Medicine Service

The national Genomic Medicine Service (GMS) will be delivered through a network of seven Genomic Laboratory Hubs. The BOB ICS is within the catchment of the West Midlands, Oxford and Wessex GLH which extends from the north midlands to the south coast. Genomic Medicine Centres continue to play a key role in supporting the implementation of the GMS, working in collaboration with their regional GLH and local clinical and laboratory services to embed genomics (and especially whole genome sequencing) within NHS practice.

The 5 year vision

The NHS vision for the new genomic medicine service is for it to provide consistent and equitable care, operate to common national standards and specifications and to be delivered against a single national test directory. All patients will be given the opportunity to participate in research both for individual benefit and to inform care for future generations, and a national genomic knowledge base will be created to facilitate academic and industry research and development. An estimated 5 million genetic and genomic tests and analyses are predicted to be carried out in the next five years nationwide, with up to 500,000 whole genome sequences completed by 2024.

Genomics in the BOB ICS

BOB Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Genomics in the BOB ICS

The BOB Integrated Care System is a key partner organisation for the Oxford Genomic Medicine Centre, and on a larger scale, the West Midlands, Oxford and Wessex Genomic Laboratory Hub. By integrating healthcare organisations from across the region, BOB ICS provides a structure for effective clinical networking across partner trusts, workforce development, and promotes access to genomics across all levels of care. Genomics is relevant to many of the established workstreams of the BOB ICS, including learning disability and autism, improving cancer outcomes, major health conditions, maternity and neonatal, and personalised medicine, and more broadly research and innovation, digital, and workforce development. Integration with these workstreams provides a valuable conduit for information and opportunity for coordination on shared priorities as the genomic medicine service is developed and rolled out nationally.

Benefits to patients

The benefits to patients of earlier and more precise diagnoses are well-documented. For rare disease patients, a genetic diagnosis provides better understanding of the cause of the condition and (in some cases) likely prognosis, it allows risk to family members to be assessed and access to reproductive options such as PIGD and PND; in some instances particular treatment might be indicated based on the result.

For cancer patients, genomic testing can help to access new drugs through clinical trials, provide information about familial cancer predisposition, and inform which therapies are likely to be successful and those which should be avoided.

In the longer term, the combination of clinical and genomic data will be used by researchers in academia and industry to further knowledge on the causes of genetic disease and enable the development of targeted therapies for the benefit of future generations.

Increased efficiency

Whole genome sequencing for rare disease has the potential to end the 'diagnostic odyssey' for patients, replacing protracted sequential genetic tests with a single step. Improved diagnostic yield allows wider access to advanced techniques for prenatal screening or PIGD, and specific programmes for neonatal and paediatric ICU mean targeted treatment can begin quickly where indicated. Genomic testing in cancer can inform treatment options and allow a personalised approach. Working to a standard national test directory, centralising laboratory processes, DNA sequencing and elements of the analysis offers economies of scale as well as providing consistency of service across the country.

Workforce development

The workforce transformation needed to support the NHS vision of a mainstreamed genomics medicine service is a substantial undertaking, necessitating a coordinated effort across clinical specialties and laboratories. Health Education England's Genomics Education Programme has been developed with this aim and provides a set of dedicated resources for healthcare professionals at all levels.

Locally, the GMC and GLH are supported by training and education leads, with staff in clinical genetics and other specialties running a series of events aiming to create productive clinical networks across relevant specialties. This approach will be strengthened by coordination across the BOB ICS through the workforce system.

Driving innovation

All patients having whole genome sequencing will be offered the chance to participate in the National Genomic Reference Library, allowing their de-identified genomic and clinical data to be used for research. This research may benefit them directly and/or lead to better understanding of genetic disease, faster diagnosis, and the potential for new treatments for future generations through links with academia and industry.

Giving NHS staff the backing they need

BOB Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

The BOB ICS People Strategy

HR Directors across BOB have identified a set of key challenges for the ICS relating to workforce and designed deliverables to achieve them (underpinned by a Culture and Leadership programme):

1. Addressing urgent workforce shortages
2. Releasing time for care
3. Redesigning workforce operating models
4. Making the NHS the best place to work

Our vision for our workforce

The overarching vision is:

- An **agile workforce** able to deliver against patient needs that is highly skilled and engaged.
- A workforce that can **operate beyond organisational boundaries**, within inclusive cultures while maintaining financial stability.
- For Health and Social care partners to **working together** to deliver our BOB-wide People Strategy

Our workforce deliverables

1. Recruitment & Resourcing (addressing workforce shortages)

- Nursing supply
- International Recruitment
- Our branding / offer
- Volunteer workforce portal
- Key Worker Housing
- Alignment of terms and conditions
- Rotational posts

2. Productivity (releasing time for care)

- Enabling digital-ready workforce
- E-Rostering across system
- Streamlining
- Quality Improvement and Standardisation (Carter / GIRFT)
- Adopt
- Model Hospital

3. Workforce Planning & Change (redesigning operating models)

- Cancer, maternity, mental health
- Therapies and reablement
- Primary Care Development
- Supporting vulnerable specialties
- Expansion of Nursing Associates, Paramedics & Physician Associates
- Develop the support workforce
- Developing LD & Autism careers

4. Supporting our staff (making the NHS the best place to work

- Build a great place to work
- Staff Health & Wellbeing
- Sickness & Absence
- Creating a supportive workplace
- Benchmarking
- Staff Engagement

	Mutual Support	Shared Projects	Joint Ventures	Strategic Partners
Visions	Different	Project outcomes	Venture outcomes	Shared future
Goals	Different	Project-level	Initiative-level	Organizational missions
Dependencies	Few, simple	Many, short-term	Many, long-term	Interdependent for survival
Measures	Different	Based on project goals	Based on purpose	Based on performance
Connections	Infrequent	Frequent Short duration	Frequent Limited	Frequent Expansive
Requests	Specific One-time	Negotiated Project Charter	Negotiated Memo of Under.	Negotiated Contracted
Activities	Communication Make requests Give support Intermittent	Plan Projects Tasks Monitoring Short-term	Plan Initiatives Tactics Decision making Medium-term	Plan Futures Strategy Identity Long-term

Deliverable 1 – Recruitment & Resourcing

BOB Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Nursing Cadet scheme

NHS Trusts in partnership with FE Colleges in the Thames Valley are currently setting up a nursing pilot scheme.The pilot programme will enable local students on B Tec and T-Level courses to undertake their placement activity within the local NHS trusts, registering on Banks and providing a clear pathway through to the Nursing Associate apprenticeship and the nursing degree programme.

HealthTec

HealthTec has been established since summer 2017 and was funded by HEE Thames Valley. Hosted by the Bucks College Group and working with the local Trust, it is seeing an increasing number of repeat bookings from schools. The facility has engaged with almost 7,000 students in 2018/19 - an impressive increase of 75% on the 4,000 engaged with in 2017/18. HealthTec's benefits include: a wider clinically credible offer, a raised profile, a potential workforce pipeline for the Trusts, and a quality experience for young people.

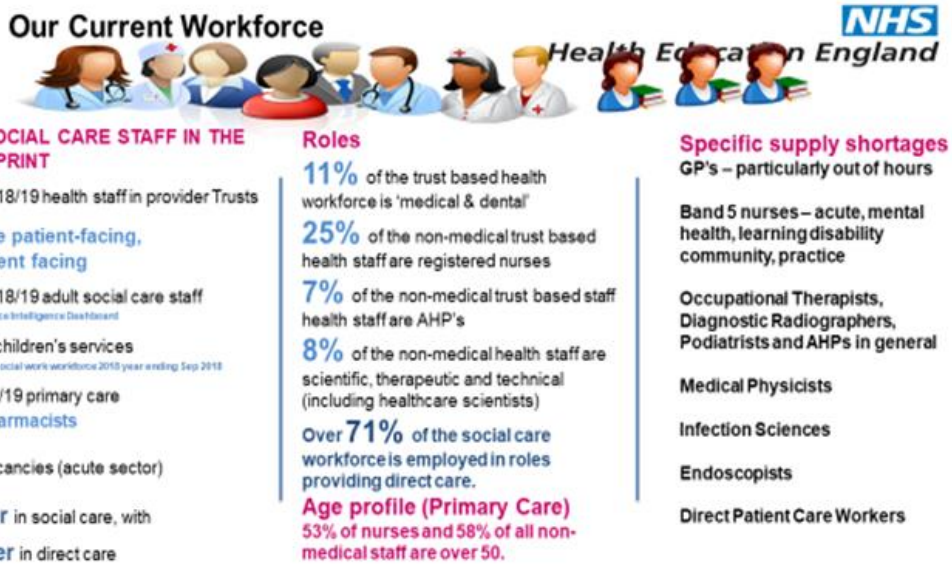
Volunteering

In Buckinghamshire, volunteering programmes increasing recruitment and improving the service to volunteers are being delivered. These improve the diversity of our volunteer base by ethnicity, age, disability and other protected characteristics. A specific Young Volunteers Programme links with the Duke of Edinburgh Award Scheme.

Oxford University Hospitals offer structured volunteering opportunities for students wanting to train as medics or clinicians and as a way of keeping skills when staff retire.

Examples of progress

- Buckinghamshire Healthcare has added 60 substantive nurses to its establishment between March and September 2019 due to international recruitment working in partnership with Portuguese Universities. It is in cohort 4 of the NHS I retention programme and has seen statistically significant improvement in the last 9 months (turnover is down to 13.5%)
- Oxford Health has 120 Nursing Associate trainees with 22 qualified. Two cohorts (approximately 50 people) will start the 18 month nursing degree top-up course in May 2020
- Rotational posts in children's' specialist community nursing and Occupational Therapy are being trialled in Berkshire
- Short-term opportunities for key worker housing have been identified in Oxfordshire, and a guide to affordable housing is nearly ready
- Oxfordshire's Recruitment Campaign is increasing support workforce recruitment each year and generating national interest from the Department of Health and Social Care



Deliverable 2 - Productivity

BOB Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

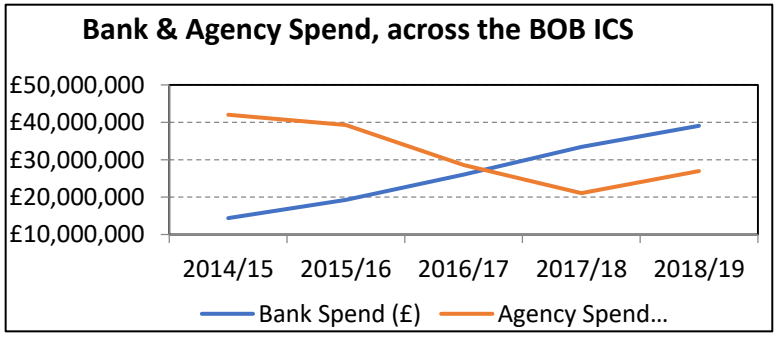
21st century digital

A key focus of our productivity workstream is to enable use of 21st century technology to support integrated care, with digitally enabled staff supported to improve earlier diagnosis (see Digital section).

Global Digital Exemplars

The benefits Berkshire Healthcare and SCAS are both GDEs. The BOB ICS benefits from a number of GDE organisations. Specific to workforce, examples include:

- Berkshire Healthcare – a solution enabling two-way communication, automated and paperless appointments and online treatments. Also includes digitising wards, services, and observations, and introducing 'live bed' capacity and real-time dashboards for the crisis team. SCAs is focussing on digitally integrated clinical patient management systems and dispatch systems;
- Virtual digital telephony platforms & electronic patient record system
- Digitisation is enabling staff to create evidence-based care packages, smart alerts and notifications. It directly supports planned and unplanned care in the community, including Skype clinician consultations.



Above chart - All NHS Trusts are now running 'Bank First' Schemes which are impacting dramatically on agency spend. Some Trusts in the ICS already have a shared Bank and others will investigate such arrangements.

Personalisation

Berkshire Healthcare is undertaking a 'Ward to Board' Quality Improvement Programme seeking to empower front-line staff to make clinical and professional decisions to support personalisation

Use of First Contact Practitioners in MSK

Qualified autonomous physiotherapists assess, diagnose, treat and discharge appropriate patients without a medical referral in Berkshire. These FCP Physiotherapists are now part of the frontline general practice team. GPs continue to see a proportion of MSK patients with FCPs providing advice and expertise into the whole primary care team. The Chartered Society of Physiotherapy (CSP) estimates that physiotherapists working as FCPs could see up to half of all patients with MSK conditions (up to 10% of all patients currently being seen by GPs). Benefits from the pilot are:

- Quicker recovery for patients with 50-70% discharged after 1 consultation
- Integration of early Shared Decision Making
- Improved use of diagnostic capacity with 3-5% cost reductions in plain X-rays and MRI scans
- More appropriate referrals into secondary care and improved conversion rates for orthopaedic surgery

Examples of progress to date:

BOB LWAB real value initiatives include 'streamlining' projects - system-wide Occupational Health, aligning pre-employment checks for doctors-in-training, common standards for mandatory and statutory training. These are reducing duplication and make it easier for staff to move from one employer to another.

OUH is using e-job planning to improve the productivity of our Medical and Dental workforce at specialty and pathway levels

Buckinghamshire Healthcare and Oxford Health are developing e-rostering and sharing learning across BOB.

Deliverable 3 – Workforce Planning & Change

BOB Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

System-wide workforce scenarios

Over Autumn 2017, key representatives of each of the three places in BOB committed to 'place-based modelling' to baseline the health and social care workforce for each place, then define future changes in care functions and skills mix. Each place-based workforce model is a baselined with identifiers for each population health segment. Each place agreed common baselining assumptions for 'as is' segmentation, which made it possible to compare and contrast current resource 'pools' with 'to be' skills mix assumptions per segment across BOB. A 'first fit' output from all three places was shared with wider stakeholders from Buckinghamshire, Oxfordshire and Berkshire West in workshops producing a 'balanced' picture of costed changes across acute, mental health, social, primary and community care workforces.

Paramedic programmes

South Central Ambulance Service (SCAS) has recently been approved as an Apprenticeship Employer provider. Various apprenticeship programmes support widening participation and progression of internal staff: Level 3 Ambulance Support worker standard (for our Emergency Care Assistants), Level 3 Emergency Call Handler standard (for our staff in Contact Centre) and Degree Paramedic apprenticeship (national). Widening participation is crucial to the "grow your own talent" approach being adopted across BOB.

BOB ICS- 45 x PCNs Year 1 then average 36 x PCNs at 50k population average					
	19/20	20/21	21/22	22/23	23/24
Clinical Pharmacist	45	81	117	153	189
Social Prescriber	45	81	117	153	189
First Contact Physio		45	81	117	153
Physicians Associates		45	81	117	153
Community Paramedics			45	81	117

Examples of progress to date

- Substantial new role uptake across ICS
- Development of Cancer Pathway Competency Framework to support regional Cancer Network programme
- Establishment of AHP Council to work collaboratively on re-ablement and rehabilitation skills shortages
- Nationally recognised Care Certificate pilot sharing learning and best practice across GP surgery support staff, domiciliary and Care Homes staff.

Deliverable 4 – Supporting our staff

BOB Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Primary Care Training Networks

GP Retention Programme – a BOB wide programme to support GPs – covers 3 major projects: mentoring, locum chambers and flexible careers. Working in partnership with Bucks Training Hub, Berkshire West Training Hub, the 3 CCGs and NHS England & Improvement.

Nurse Bursary Scheme – using GPN10 PP funding to establish a bursary scheme (where nurses can access 60% of course funding) with practices supplying the remaining 40%. This encourages practices to support the nurse in attending training and implementing new skills within general practice.

Signposting & Frontline – last year Oxfordshire ran county wide programmes to help reception teams better manage patient contacts and direct them to the most appropriate service or clinician. They are sharing case studies about how this has helped practices.

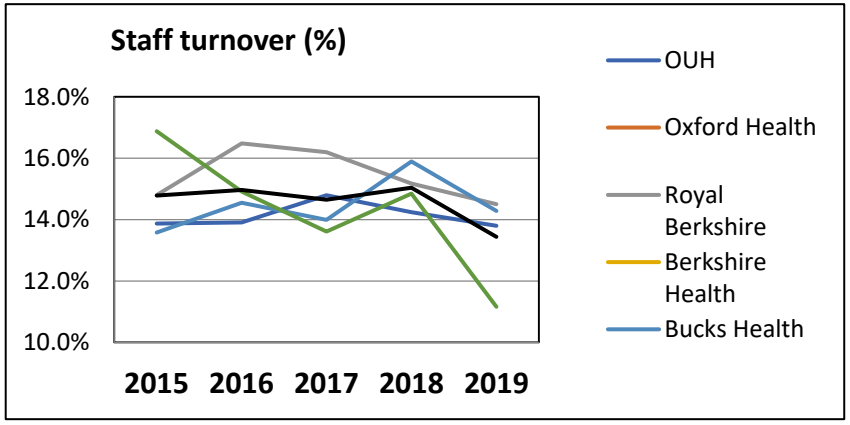


Chart above - Trusts are sharing best practice in ED&I, health and wellbeing, and adopting a 'zero tolerance' approach to bullying and harassment.

Project Search

In September 2018 Royal Berkshire welcomed its 7th cohort of Project SEARCH students. Project SEARCH is a unique collaboration which supports young people with learning disabilities transition from education into the world of paid employment. This year we welcomed 10 students from Reading College and Brookfield's SEN School. Since the start of the project, 19 young people graduating from the programme have secured employment at the Trust, working in a variety of full time and part time roles in departments including the mattress library, endoscopy, medical records and portering services. Additionally, eight graduates have secured paid roles within their local communities with employers outside the NHS.

Examples of progress to date:

- NHS Trusts have shared their staff satisfaction survey results, and are aiming collectively for a 2% increase in staff engagement scores by the end of 2021 and a 5% decrease in bullying and harassment during 2020.
- and improvement in Staff Survey metrics in bullying, discrimination and fairness of career development opportunities
- All Trusts are running Leadership and Management development programmes – BOB employers are targeting over 2000 staff through these by year 3.
- OUH's 'Retire and Return' scheme encouraged 35 staff to re-engage in 2018-9, and to date 19 individuals in 2019-20.
- Oxford Health has launched a significantly improved Preceptorship Programme to provide greater support to newly qualified Nurses

Enabled by culture & leadership

BOB Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Improving the leadership culture

Our leaders across the ICS will be encouraged to work and develop together and to develop their cross system leadership. We will focus on developing local talent and will encourage effective succession planning. Our workforce will be offered a career pathway.

Leadership grounded in Equality, Diversity & Inclusion

Equality, diversity and inclusion will be championed across all employers. Leadership grounded in Equality, Diversity and Inclusion
Wherever possible, leadership courses are being shared. Berkshire is running the Henley leadership programme; SCAS' leadership programme has substantial uptake.

Trust HRD's are adopting a collaborative approach to ED&I, committing to representative senior staff structures with at least 12% BAME backgrounds by year 2 (2021)

Individual organisations run schemes to improve inclusion. For example Buckinghamshire Healthcare recently launched a supported internship with 8 students from a local special needs school, which will run throughout this academic year.

Progress to date:

- Work is under way to create a BOB Leadership and Improvement Collaborative (BLIC). This will be a dedicated sub-committee of the BOB LWAB for all Leadership, Talent and OD intervention design and decision making across the ICS. Best practice at organisational and ICP level will ensure these interventions create the required shift in mind-set, behaviours and skills necessary to deliver objectives
- Professional support networks have been established for Chief Nurses, AHPs, Care Home Managers and across Primary Care
- NHS Trusts are collaborating to create joint management training programmes, and to offer shadowing and secondment opportunities
- Talent plans are being shared across Trusts to ensure best practice and to create a system-wide Talent Strategy using expert facilitation and support to ensure coherence with national and regional talent approaches
- All NHS employers are running mentorship schemes: For example SCAS runs two schemes - a Level 6 accredited Mentorship course to equip experienced clinical mentors and one aimed at offering staff the basic mentorships skills and overview before they are allowed to supervise a student or a new member of staff.

	At at end March				
Staff turnover (%)	**2015**	**2016**	**2017**	**2018**	**2019**
OUH	13.9%	13.9%	14.8%	14.2%	13.8%
Oxford Health					
Royal Berkshire	14.8%	16.5%	16.2%	15.2%	14.5%
Berkshire Health					
Bucks Health	13.6%	14.5%	14.0%	15.9%	14.3%
SCAS	16.9%	14.9%	13.6%	14.8%	11.2%
STP Average	**14.8%**	**15.0%**	**14.6%**	**15.0%**	**13.4%**

Risks & Mitigation

BOB Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

TOP TEN RISKS	MITIGATION
High social care turnover and challenges recruiting experienced staff	Care Certificate pilot in Care Homes and domiciliary care linked to GP surgeries. Work with Care Home providers to establish registered managers networks.
General Practitioner and primary care workforce shortages	Analysis has shown the size of the gaps. Primary Care Training Hubs across BOB collaborating alongside a GP retention scheme. Primary Care Nurse Bursary scheme to enable Nursing Associates to train for Practice Nursing.
BOB-wide shortage of professions targeted in Primary Care Network recruitment – experienced AHP's, paramedics and pharmacists	Phased recruitment to enable response; rotational posts (e.g. SCAS paramedics; OT's) to ensure service continuity
Digitalisation will require alignment of IT systems or common platforms which are not yet in place	Pragmatic approach to shared procurement (e.g. E-rostering) aligning as opportunities occur.
Short-term nature of workforce transformation programme funding (only funded to March 2021)	Work is ongoing through LWAB to identify other sources of funding and to build sustainable business cases.

TOP TEN RISKS	MITIGATION
Changes in funding modelling for nurse education – i.e. removal of bursaries; introduction of apprenticeships puts a significant additional financial burden on Trusts	Working with partner universities to find a curriculum that meets the NMC requirements, and is as short as possible.
Nurse vacancy rate and therefore reliance on overseas recruitment. Increase in costs, increase in uncertainty due to Brexit	Trusts have focussed recruitment on different specific countries, streamlined processes and are increasingly 'growing their own'.
Retention challenges due to high cost of living creates high turnover/churn. Analysis shows that staff resident in BOB are often travelling for London weighting.	Key worker housing initiative; career pathway development; retire and return schemes, strong CPD. OUH is preparing a business case seeking extension of weighting.
Oxfordshire reablement service shortages result in 30% of those with delayed transfers of care in hospital beds. Nursing and AHP shortages in the acute have closed 26 acute and 12 community beds.	Local Workforce Action Board reablement and rehabilitation initiative is being planned with the newly established AHP Council to resolve AHP and reablement shortages across BOB.
Medical specialties closing due to staff shortages in at least one 'place' in BOB or in neighbouring DGH's	Commissioning across BOB for short-term provision; vulnerable specialties initiative to share teams

Governance is currently co-ordinated at BOB LWAB, with place-based or clinical programme delivery (e.g. Training Hubs, Cancer, Mental Health and Maternity programmes). From Nov 2019 onwards, to reflect the Interim People Plan approach, BOB LWAB will be migrating to a Workforce Transformation Programme with workstreams and key deliverables as outlined above.

Workforce data chart / graph

Content to add

Digitally-enabled care across the BOB ICS

BOB Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Context

The BOB ICS is committed to using digital technology to help the local health and care system to achieve its wider transformation agenda and where possible deliver projects at ICS level to achieve efficiencies of scale and strongest return on investment for stakeholders.

We have all made significant investments to our ICT and digital solutions at Place and our aim is to ensure those investments are built on and, in some cases, that will remain at Place.

Our aim is to deliver digital solutions which increase convenience and choice for our users and are easy to use and navigate. This will ensure increased adoption of digitally enabled care across the ICS and transform the way patients engage with services, support joined up care and improvements to quality, efficiency and health outcomes for the population.

To baseline our current levels of digital maturity each ICP within BOB ICS has completed an assessment of its digital maturity. This evidence base will be used to understand current capabilities across BOB and identify areas for improvement. We will use our digital maturity baseline to inform our work to develop and improve digital maturity across BOB.

BOB digital priorities

BOB has the following **six** digital priorities**:**

- A new service model for the 21st century
- Empowering people
- Supporting health and care professionals
- Supporting clinical care
- Improving population health intelligence
- Improving clinical efficiency and safety

Delivering our Digital objectives (summary)

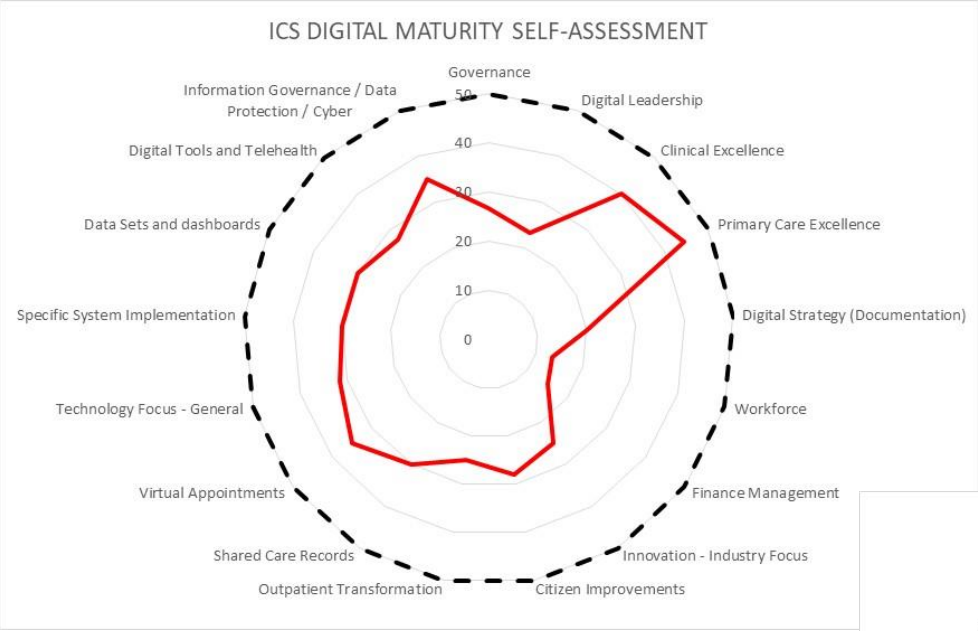
BOB Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

2019-20 – Deliver for today	2020-2023 – Transform for tomorrow	2023 and beyond – Underpin the future
▪ Commence the BOB CIOs Forum ▪ Review all service delivery models and develop business case for improvement ▪ Baseline current ICS systems to identify overlaps, gaps and opportunities to provide business and patient benefits. The ICS will build on place investments and identify integration methods to improve productivity. ▪ Support key workers by providing digital tool to replace travel with digital ▪ Roll out of NHS App and other on-line tools to develop a self-serve culture ▪ Connecting older adults to care and health / telehealth in care homes ▪ Making essential infrastructure changes - moving to Windows 10 by June 2020 ▪ Mobile working is critical to new models of care delivery. Further investment is sought across ICS partners to ensure NHS organisations continue progress ▪ Remove fax machines by April 2020, replace bleeps and pagers, enable video conferencing and unified communications solutions to reduce the costs such as lost travel time ▪ Sharing of transformation ideas across BOB	▪ Move to paper free ▪ Deliver virtual consultations for elective care, mental health, community prevention services & outpatients (interactive referrals) ▪ Support the digital first primary care programme – e-consultations, standardising GP appointments, and virtual appointments ▪ Continue to develop EPR programmes ▪ Implement electronic prescribing ▪ Joint working with SCAS on 111 direct bookings into primary care practices ▪ Care home patient flow via digital enabling ▪ Achieving 100% compliance wit cyber security standards by 2021; exiting from N3 network to the HSCN; and keep pace with increasing cyber threats ▪ Place implementation of shared care record ▪ New digital therapeutics based on patient self-management ▪ Implement VOIP to deliver cost saving ▪ Explore wider use of cloud for infrastructure ▪ Improve access / implement single sign-on ▪ Introduce digital apps for disease education, and promoting self-management ▪ Develop PHM and BI for PCNs ▪ Decision support for diagnoses and referral, with intelligent medical imaging ▪ Continue digital access to key records such as maternity, personal held records, COPD ▪ Improve tools for falls prevention ▪ Use of AI based tools, to reduce workload, open capacity and support living at home ▪ Participation in National Pathology Network	▪ Work towards HIMSS level 6/7 ▪ New models of integrated care via information sharing ▪ Improve data quality in clinical/social care ▪ Use of AI to improve clinical coding ▪ LHCR – deliver a full joint shared health and social care record ▪ Full availability of electronic hand-held notes (inc. red book for maternity and children's) ▪ Demand and capacity management dashboards – primary, secondary, social care ▪ Development of the BI pathway ▪ Culture of evidence-based decision making ▪ Identify and develop strategic BI champions across the system (e.g. Board champions) ▪ Invest in BI training and development (professionalisation of BI in line with finance) ▪ Development of an integrated PHM function(s) that will deliver PHM solutions and support at every stage of the PHM learning/commissioning cycle: o Understanding population and health care (e.g. risk stratification) o Opportunity analysis & targeting (e.g. AI machine-based learning tools) o Predictive system Modelling (e.g. system dynamic modelling & forecasting); o Design and implement interventions (e.g. system dynamic modelling) o Active monitoring and improvement (e.g. evaluation frameworks; and performance management frameworks).

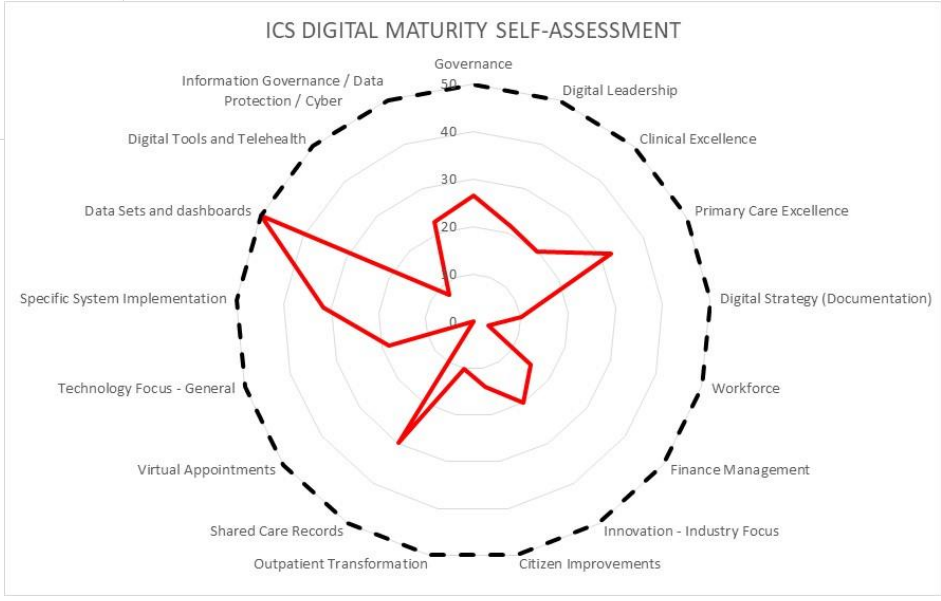
Digital Maturity (by place)

BOB Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

West Berkshire ICP



Buckinghamshire ICP



Oxfordshire to add

BOBs role in LHCR & GDE

BOB Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

BOB role in the LHCR

The Digital Workstream of the BOB ICS oversees the delivery of the LHCR work programme to ensure it meets the priorities for the BOB ICS as well as supporting it through coordination of place-based developments to ensure compatibility locally. Proposal:-

- Bi-monthly update from LHCRE SRO and Programme Director into BOB ICS digital SRO. Report to include exception reporting versus Programme milestones on a quarterly basis. To include the main delivery areas including but not limited to: -
    - Shared Care Record
    - Person Held Record
    - Population Health Management
- Report on delivery of benefits versus plans at frequency to be determined in discussion with LHCRE SRO and Project Director

Global Digital Exemplar

BOB has the following Trusts with Global Digital Exemplar (GDE) status, which will be used a strong base to form a BOB CIO Group to share learning, identify joint opportunities, share best practice and integrate services for those receiving care and working cross border.

- Oxford University Hospitals NHS Foundation Trust
- Royal Berkshire NHS Foundation Trust (Fast Follower)
- Oxford Health NHS Foundation Trust,
- Berkshire Healthcare NHS Foundation Trust
- South Central Ambulance Service NHS Foundation Trust

BOB is fortunate to have the Oxford Academic Health Science Network as part of its ICS and will work together to develop innovative solutions to improve patient safety, outcomes and experience, and generate economic growth through collaboration between the NHS, industry and universities.

Our digital objectives – narrative (1)

BOB Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

A new service model for the 21st century

We will ensure the development and effective use of technology across the ICS to improve joined-up working, information access and sharing. We will capture this in a clear ICS vision and set of deliverables to support place-based developments and ensure that every opportunity is taken to develop solutions at ICS level. Key activities. See objectives summary for activities examples.

Empowering people

We aim to increase the choice of access for patients using digital services. The NHS App will facilitate processes to support self-management of care and enabling connection to the right local services quickly. In future, automated signposting and guidance will be provided to patients where appropriate. Face to face consultations will be reduced where virtual clinics, pre-op assessments and triages can be easily undertaken within the confines of choice and need.

To support people to stay healthy and manage complex conditions several projects have been developed that will ensure easy access to digital tools regardless of their digital literacy. The ICS will explore the use of a single digital front door for citizens to replace all public websites underpinned by a system-wide digital passport. All interactions an individual undertakes with the council, GP, hospital, housing association, etc., will be documented and stored so that they are accessible across the system.

In addition to these initiatives the following summarise some of the key programmes:

- Citizen access to their records and care plans, including personal held records (PHR) (to be joined up at LHCR level), cancer personal record and the Maternity Red Book.
- Social prescribing to connect people to community groups and statutory services for practical and emotional support.
- GP Connect to enable sharing of information (e.g. appointments) between practices to provide more convenient care for patients.
- 111 Online for patients to get urgent healthcare online.
- Expansion of online digital therapies, including but not limited to IAPT, remote monitoring of acute diabetic and hematology patients' services across BOB to improve accessibility of these services to patients.
- We will continue to co-design with our patients and wider stakeholders so that we ensure the digital solutions provided are shaped around individual need and convenience.

Improving Population Health Intelligence

See Population Health Management section.

Our digital objectives – narrative (2)

BOB Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Supporting health and care professional

BOB will make improvements to our digital infrastructures and the provision of digital tools to reduce burden on our workforce to better support staff in their roles. Improvements include:

- Unified communications – roll out VOIP across BOB
- Ease of access – ambition to have single sign on where possible
- Unified Wi-Fi – provision of a standard (NHS) Wi-Fi to facilitate easy log on to support working across multiple sites.
- Increased provision of mobile data where Wi-Fi I unavailable
- Digitising care homes across BOB
- Shared tools/applications – moving towards using Office 365
- Accredited cyber security – NHS and social care systems/data are secure through implementation of security, monitoring and staff education
- Mobile digital services – including closer working across communities and increased ability to share PACS images

BOB is committed to supporting consistent mobile working across all our services - health, social care and other public sector departments. We will address barriers to mobile working such as inconsistent internet connectivity through solutions such as the use of GovRoam, a wireless/Wi-Fi roaming service for public services and government departments, seeking to procure and fund at BOB level.

Our workforce will be supported in developing digital skills so they can maximise use of digital tools provided and use them to their full potential. This will be achieved through a range of methods including the following:

- Training teams will deliver various forms of IT/system training
- Digital transformation teams to assist with implementation and adoption
- Development of partnership arrangements with local and national academic institutions to support innovation and workforce development. Participation in the NHS Digital Academy, medical and nursing educational establishments

Supporting clinical care, Improving Clinical Efficiency & Safety

BOB developments to support clinical care include:

- Joining up in key areas such as children's services so that there is a single view of the child for health and social care.
- OUHFT, RBFT, BHFT and OHFT GDE programmes to expand their EPRs with acute trusts achieving HIMSS level 6/7 for those that are GDEs and level 5 for those acute trusts that are fast followers.
- Real-time data capture – clinical noting, e-Observations, electronic prescribing.
- Implementation of Electronic Prescribing and Medicines Administration (ePMA) solutions (where not already in place) across the system to improve patient safety and quality of service. Meeting national standards for the e-Referrals Service (e-RS).
- A TVS wide cancer image sharing and reporting system.
- Comprehensive TVS wide shared care record linking place based shared care records.
- Effective clinical decision support in place for primary care.
- Eclipse system for primary care to help practices manage patient with long term conditions.
- BOB will partner with academic institutions such as the Oxford AHSN and the commercial sector to develop new approaches and solutions to drive forward improvements in clinical care and patient outcomes. Across BOB a number of such initiatives are planned or underway such as the formation of the Mental Health Biomedical Research Centre between OHFT and the University of Oxford which will be embarking on a number of digital projects in areas such as CRIS, PROMS and virtual reality.

Capital & Estates

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

To note

Fuller detail on BOB ICS planning for capital and estates will be completed for the final system plan submission, which will align to the BOB ICS Estates Workbook. This slide sets out information submitted as part of the capital and estates section of the BOB 2019/20 Operational Plan

Current and forthcoming BOB ICS capital & estates activity

Over 2018/19 the BOB ICS has demonstrated that the system is working together to support the improvement of the NHS estate (via the BOB ICS Estates workstream). This work has progress through collaborative working across places and organisations to deliver:

- Production of a vision and priorities for BOB ICS Estates activity, and plans by organization for the development of place Estates work
- Development of a prioritisation framework to inform strategic estates and capital investment across the three places within BOB – to be carried forward into capital investment processes
- Prioritisation and consolidation of the three place strategies into BOB ICS estates and capital investment priorities. Capital investment priorities and plans were rated 'good' by NHSE/I.

This work will continue into 202/21 and beyond to aligning the estates priorities and vision with the overall priorities and vision of the ICS. Work will include focusing on development and delivery of robust, affordable local estates strategies that include delivery of agreed surplus land disposal ambitions across places and the ICS as set out to the right.

- Monitor progress on delivery of Wave 1-4 capital schemes and escalate any issues to BOB ICS Senior Leaders Group.

- Continue oversight role in respect of place and organisational estate strategies to address recommendations included in NHSE/I feedback on BOB ICS Estate priorities, these being:
  - Working with place teams to reassess disposal pipeline and proposed phasing to develop a robust disposal plan
  - Link with ICS and place clinical priorities to drive a clear view of estates implications across the ICS including potential future developments and pipeline of bids for subsequent national funding (Wave 5 and beyond)
  - Continued work with the Primary Care workstream to develop a strategy for driving primary care and community services estates priorities
  - Align ICS priorities with other providers such as South Central Ambulance Services NHS Foundation Trust