BOB Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Joint Forward Plan

May 2023

DRAFT – WORK IN PROGRESS

Welcome and Foreword

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

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

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

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

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

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

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

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

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

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BOB Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

01
Introduction

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1.1 Purpose of the Joint Forward Plan

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

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

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

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

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

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

Delivering our Integrated Care Strategy

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

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

2023/24 Operational Planning Requirements

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

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

Delivering the JFP within our 2023/24 financial allocation

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

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

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

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1.2 Our System Landscape

Our health and care landscape

BOB Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

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

Our unitary / upper tier councils

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

Population of nearly 2 million

Approx. 68,000 staff in health and care

50+ primary care networks

Thames Valley Cancer Alliance

NHS Oxford Health NHS Foundation Trust

NHS Berkshire Healthcare NHS Foundation Trust

2 Community and mental health trusts

NHS Royal Berkshire NHS Foundation Trust

NHS Buckinghamshire Healthcare NHS Trust

NHS Oxford University Hospitals NHS Foundation Trust

3 Acute / integrated hospital trusts

NHS South Central Ambulance Service NHS Foundation Trust

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1.3 Our Place Based Partnerships

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

Our Place Based Partnerships (PBPs)

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

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

The role of PBPs in delivering local priorities

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

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

PBPs will focus on the following populations:

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

Developing our PBPs

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

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

Health and Wellbeing Boards

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

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

1.4 Our Provider Collaboratives

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

BOB Acute Provider Collaborative

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

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

Our Acute Provider Collaborative is committed to:

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

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

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

BOB Mental Health Provider Collaborative

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

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

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

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

Developing our Provider Collaboratives

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

1.5 Our Wider Partnerships

Our Clinical Networks

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

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

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

Voluntary, Community and Social Enterprise

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

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

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

Our communities

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

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

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

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

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

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

Our broader social and economic contribution

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

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

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Addressing Our Biggest System Challenges

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2.1 Understanding Our Population's Health Needs

Understanding our population, their health needs and recognising inequalities

Our population's health needs are increasing

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

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

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

Our Demographics

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

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

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

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

Our Population Health

Start Well

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

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

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

Live Well

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

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

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

Age Well

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

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

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

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2.2 Understanding Our Population's Experience

Citizen Experience Research

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

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

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

Public Engagement on the Integrated Care Strategy

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

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

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

Core Services are not easy to access

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

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

Memorable wait times are defining citizen experiences

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

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

National Themes for the NHS

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

2.3 Understanding Our Performance

Recovering Performance from the impact of Covid-19

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

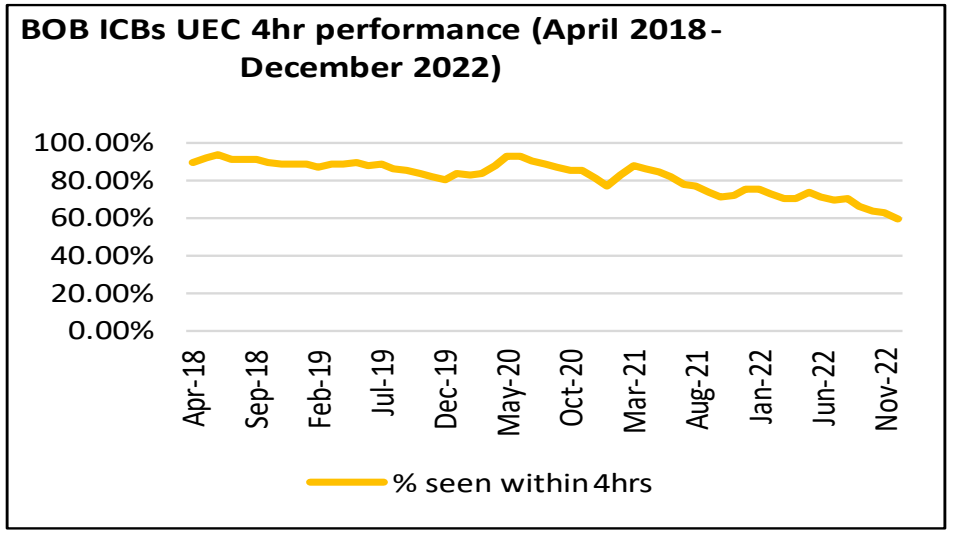
In the context of this focus on recovery, it is important we fully recognise the current challenges we face. This section outlines some of our key performance challenges across Urgent and Emergency Care, Planned Care, Primary Care and Mental Health services, alongside some of our critical workforce and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

Urgent and Emergency Care

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

Accident and Emergency 4 hour Performance

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



Ambulance Handovers delays:

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

No Criteria To Reside

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

Urgent Care Centres

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

Virtual Wards:

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

Urgent Community Response

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

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

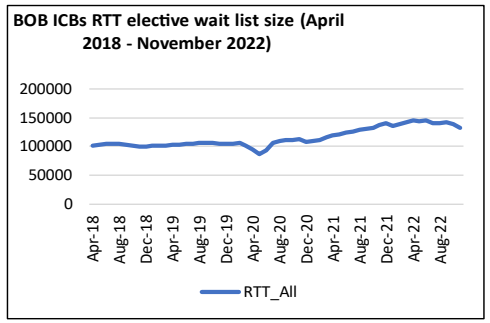
2.3 Understanding Our Performance

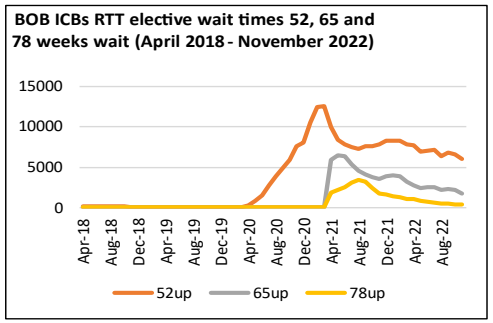
Planned Care

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

Waiting times for planned treatment

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





Cancer

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

Productivity

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

Diagnostics

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

Primary Care

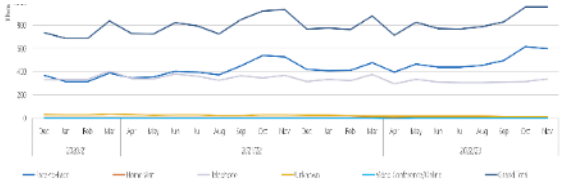
It is important for people in BOB to be able to see their GP quickly, and access other primary care services such as dentists and pharmacists, when they need to. We know that when people cannot access these services promptly, they are more likely to rely on other services that are already under significant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

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

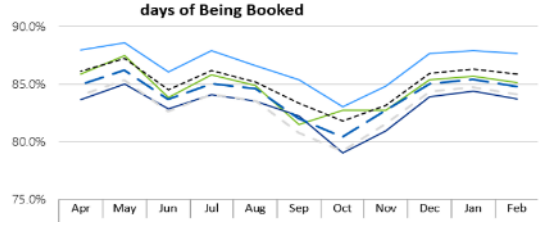
The ICB has been working to increase capacity in general practice, including an additional 2000 sessions of clinical time and additional capacity in acute respiratory infection 'hubs'.

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

A steady increase in GP appointments across BOB



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



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

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

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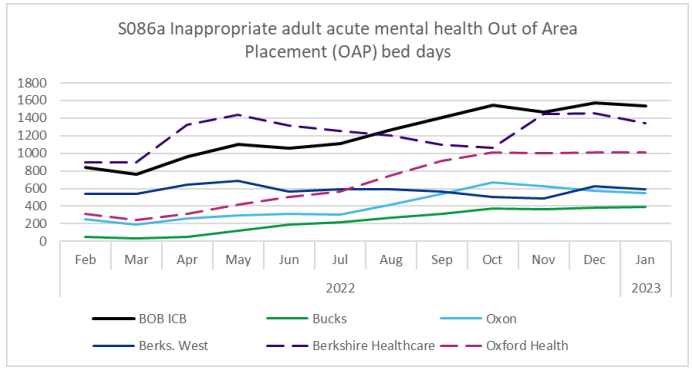
2.3 Understanding Our Performance

Mental Health

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

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

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



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

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

2.4 Understanding our Sustainability – Finance

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

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

Pre-Covid identified drivers of underlying deficit

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

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

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

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

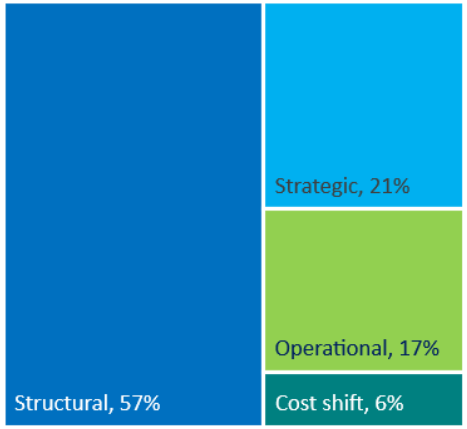
Strategic (21% of underlying ICS deficit pre-Covid)

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

Cost shifts

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

Pre-Covid drivers of deficit by theme



Post-Covid drivers of underlying deficit

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

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

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

Addressing the underlying deficit

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

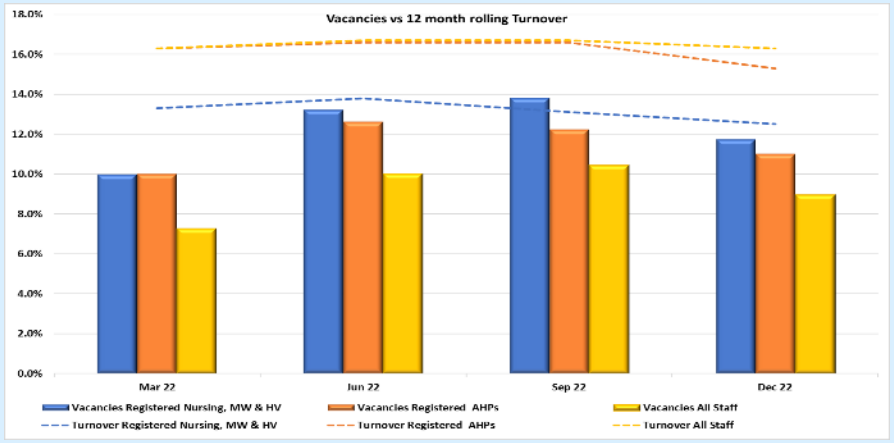
2.4 Understanding our Sustainability – Workforce and Environmental

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

Our Workforce

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

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



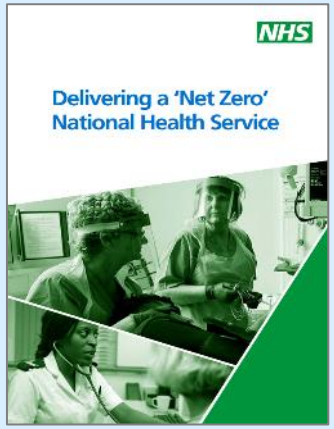
Our Net Zero Commitments

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

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

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

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



Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

2.5 Our Biggest System Challenges

As a system, we have a comprehensive understanding of:

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

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

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

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

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

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

2.6 Developing Our System Response

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

Steve McManus
Stephen Chandler
24 March 2023

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

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

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

1/ A commitment to doing things differently

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

2/ System coordination with local delivery

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

3/ Prioritising our resources to communities with greatest need

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

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

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

5/ Utilising existing governance structures to make it happen

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

6/ The importance of working together

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

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

2.7. Addressing our Inequalities Challenge

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

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

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

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

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

Service Plans Reference:

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

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

Our longer term transformation approach – Unlocking population health management

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

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

2023/24 Priority Transformation Milestones

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

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

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

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

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

2.8. Addressing our Model of Care Challenge

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

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

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

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

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

Service Plans Reference:

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

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

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

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

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

2023/24 Priority Transformation Milestones

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

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

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

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

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

2.9. Addressing our Experience Challenge

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

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

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

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

Service Plans Reference:

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

Our longer term transformation approach

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

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

2023/24 Priority Transformation Milestones

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

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

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

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

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

2.10. Addressing our Sustainability Challenge - Workforce

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

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

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

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

Service Plans Reference:

- Workforce

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

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

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

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

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

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

2023/24 Priority Transformation Milestones

Q1

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

Q2

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

Q3

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

Q4

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

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

2.10. Addressing our Sustainability Challenge - Financial

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

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

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

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

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

Service Plans Reference:

- Finance

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

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

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

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

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

2023/24 Priority Transformation Milestones

Q1

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

Q2

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

Q3

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

Q4

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

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

2.11. 2023/24 Delivery Architecture

Oversight of delivery

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

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

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

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

2023/24 Building the foundations for change

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

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BOB Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

03

Delivering Our Strategy

Our Five-Year Joint Forward Plan:

DRAFT

Buckinghamshire, Oxfordshire and Berkshire West
Integrated Care System

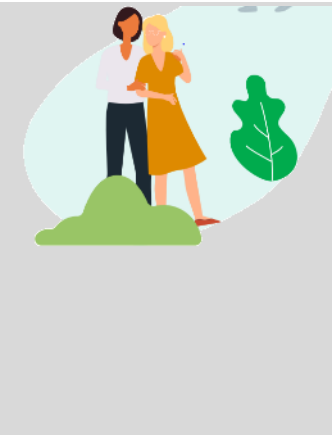
3.1 Promoting and protecting health

3.1 Promoting and Protecting Health

Keeping people healthy and well

Promoting and Protecting Health

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



The importance of prevention

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

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

Our focus areas

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

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

3.1 Promoting and Protecting Health – Our Summary Plan

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

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3.2 Start well

3.2 Our Joint Forward Plan: Start Well

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

Starting Well in BOB

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

Supporting children and young people

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

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

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

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

Our focus areas

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

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

3.2 Start Well – Our Summary Plan

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

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3.3 Live Well

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

3.3 Our Joint Forward Plan: Live Well

Supporting people and communities to live healthier and happier lives

Living Well in BOB

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

Supporting people to manage Long-Term Conditions

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

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

Our focus areas

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

Long Term Conditions

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

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3.3 Delivering Our Strategy – Live Well

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

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3.3 Delivering Our Strategy – Live Well

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

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3.4 Age Well

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3.4 Our Joint Forward Plan: Age Well

Staying healthy and independent for longer

Aging Well in BOB

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

Supporting older people to remain healthy

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

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

Our focus areas

1 Age Well Services

3.4 Delivering Our Strategy – Age Well

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

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3.5 Improving quality and access

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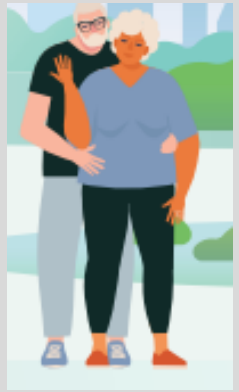
3.5 Our Joint Forward Plan: Improving Quality & Access to Services

Accessing the right care in the best place

Better access to quality services

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

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



Supporting people to access our quality services

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

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

Our focus areas

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

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Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

3.5 Delivering Our Strategy – Improving Quality and Access

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

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

3.5 Delivering Our Strategy – Improving Quality and Access

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

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3.6 Supporting and Enabling Delivery

3.6 Supporting and Enabling Delivery

Building and growing the foundations of successful delivery

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

Our Enabling Plans

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

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

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

- Workforce
- Digital and data
- Finance
- Estates

Our Supporting Plans

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

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

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

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3.6 Delivering Our Strategy – Key Enablers for Delivery

Enabled Through

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

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