

Joint Forward Plan - Summary Position

Buckinghamshire Health and Wellbeing Board

March 2023

Joint Forward Plan (JFP) requirements

- JFP is a new **joint statutory responsibility** for ICB and NHS Trusts
- The JFP should describe, as a minimum, how the ICB and its partner trusts intend to arrange and/or provide NHS services... including **delivery of the universal NHS commitments**
- Systems are encouraged to use the JFP to develop a **shared delivery plan for the Integrated Care Strategy**
- A number of statutory requirements that the JFP must address – e.g. duty to improve quality, duty to promote integration etc.



JFP Structure – Aligns to Integrated Care Strategy



The challenge will be balancing the short term delivery vs long term ambition

- Promote prevention
- Address inequalities
- Deliver in partnership

Our Vision 01	Everyone who lives in our area has the best possible start in life, lives happier, healthier lives for longer, and can access the right support when it is needed				
Our System Partnerships 02	Place based partnerships, Neighbourhood teams (PCN led), Clinical Networks, Provider collaboratives				
Addressing Our Biggest System Challenges 03	Priorities to be agreed				
Delivering Our Strategy – Our Five Year Delivery Plans 04	Promote and protect health: Keeping people healthy and well	Start Well: Help all children achieve the best start in life	Live Well: Support people and communities live healthy and happier lives	Age Well: Stay healthy, independent lives for longer	Quality and access: Accessing the right care in the best place
	<ol style="list-style-type: none"> 1. Prevention 2. Inequalities 3. Vaccination and Immunisations 4. Weight Management 	<ol style="list-style-type: none"> 1. Maternity 2. Children and Adult Mental Health Services 3. Learning Disabilities 4. Neurodiversity 5. Children with Long Term Conditions 	<ol style="list-style-type: none"> 1. Long Term Conditions (stroke, cardiovascular disease, diabetes, respiratory) 2. Adult Mental Health 3. Cancer 	<ol style="list-style-type: none"> 1. Community multi-disciplinary teams (e.g. frailty) 2. Palliative and end of life care 	<ol style="list-style-type: none"> 1. Primary care 2. Urgent and Emergency Care 3. Planned care
Supporting and Enabling Delivery 05	Workforce, Finance, Digital, Estates, Research & Innovation, Net Zero, Quality, Personalised Care, Continuing Healthcare				

JFP Progress to date

- We have made rapid progress in building a draft end-to-end JFP document
- c. 25 delivery plans developed – services, cross cutting functions, enablers.
 - Context – Outcomes, performance, challenges, national requirements
 - Ambition – 5 Year ambition
 - Workstreams / Projects – Plans: Y1, Y2, Y3-5
 - Enablers / Support required to deliver
- Plans developed and/or tested through system networks – e.g. UEC Programme Board, MH Partnership meeting
- Aligned to strategy structure and priorities
- Year 1 (2023/24) links with priorities and metrics required for the operational plan

Our Context and Ambition: CYP Mental Health

Context: Our challenge in BOW

- NHS England Survey 2021 showed rates of mental health disorders increased since 2017:
 - Schizophrenia: 11.8% to 17.4%
 - 17.10 year olds: 10.1% to 17.4%
- CYP Mental Health (MH) services are provided collectively by the NHS and Local Authorities across BOW, for young people up to the age of 18. This includes a range of early intervention, long term, crisis and specialist services.
- CYP population in BOW has grown at rate of 0.83% (slightly above national average of 0.66%). However growth in demand for CYP MH has been growing at a significantly higher rate (32%).
- There has been a significant increase in duty and complexity of need in young people requiring support from CYP MH services. This includes complex wellbeing disorders, autism and adverse life events resulting in demand across hospital settings, residential settings and/or social care.
- Service performance has not recovered to pre-pandemic levels and there is a rise in unmet demand and complexity.

Our Ambition: By March 2025, we will have delivered improved mental health and wellbeing outcomes for children and young people (ages 0-25), living, learning and working in BOW. To achieve this, we will take a needs led and person-centred approach (in line with the three frameworks) to implementation, transformational change and delivery.

To Deliver Our Ambition, We Will:

1. Improve timely access and early intervention to universal care and support across our system.
2. Develop a successful population health approach to supporting those most at risk of mental ill health (focusing on early identification, support and prevention).
3. Tackle the social factors and inequalities that create risk to mental health and wellbeing and increase the prevalence of mental health conditions.
4. Enable young people to access equitable provision of care and support regardless of age or the complexity of their mental health recovery journey.
5. Enhance support for CYP when they experience a mental health crisis, providing needed enablement to ensure that recovery-based solutions.
6. Use school-based approaches that build resilience and promote integration to ensure that our CYP have the sustainable skills to thrive.

What Our data shows
BOW's performance for respiratory services is currently X, compared with a national performance of Y.

What We Need For Success:

- All system partners will require a shared understanding of the IJRWG Framework and an agreement of their role in helping young people to thrive and to secure the right resources and support, at the right place and at the right time.
- Goals in provision and adaptation in order to reach vulnerable groups will need clarification and review in line with the framework to be fully inclusive.
- Targeted workforce development across the system to support the development of a 100%+ mental health managed analysis.
- Governance structures to be established across the system to support the development of a 100%+ mental health managed analysis.
- System leaders work jointly to reduce barriers to appropriate care for young people in care, adhering to core principles of joint working.

38 **DRAFT – WORK IN PROGRESS**

Our Joint Forward Plan For CYP Mental Health

What We Will Do	Planned Outcomes – What Are We Trying to Achieve	Our Delivery Plan – How We Will Do It		
		Year One	Year Two	Years Three - Five
01 Improve timely access and early intervention to universal care and support across our system.	By March 2025 there will be: <ul style="list-style-type: none"> Defined and improved mental health and wellbeing outcomes for children and young people. System wide understanding of the IJRWG Framework. All CYP will have access to timely advice and wellbeing support in schools when and where they need it. Efforts in getting help and getting more help mental health provision will be clear with agreed access and waiting times. 	<ul style="list-style-type: none"> Review current service models and approaches across the ICS informed by the IJRWG assessment tool. Define what 'good' would look like. Detail existing gaps, variations and inconsistencies in provision. Engage with participation groups to inform and promote improvements. 	<ul style="list-style-type: none"> Finalise action plan to: <ol style="list-style-type: none"> reduce gaps, weaknesses and inconsistencies identified by the IJRWG assessment tool and build on existing practice and good practice identified. Identify vulnerable groups and variations in provision required to make access to support equitable. Agree outcome measures. 	<ul style="list-style-type: none"> Deliver changes and improvements identified and agreed in year 1 and 2. Work with all system partners to embed early intervention and support using the IJRWG Framework. Monitor agreed outcome measures to identify progress against action plan. Repeat the IJRWG assessment tool at year 5 to identify improvements.
02 Develop a successful population health approach to supporting those most at risk of mental ill health (focusing on early identification, support and prevention).	By March 2025: <ul style="list-style-type: none"> There will be a defined and agreed approach to Population Health Management to support the implementation of anticipatory, preventive and personalised care models for CYP and their families. There will be a map of the variations in need and outcomes across the system and of place. There will be agreed metrics that will inform service design, transformation, commissioning and delivery driven by PHG data. 	<ul style="list-style-type: none"> Review existing national and localised population health data to identify known gaps in provision. Agree data road map. Identify population health lead/proposed support for CYP. Work with ICS and key stakeholders to provide oversight of data improvement and continued population health approach. Agree strategic, population health-based approach to developing services. 	<ul style="list-style-type: none"> Embed governance and structures to facilitate working collaboratively with providers, partners and stakeholders. Agree and initiate systems for monitoring progress and change. 	<ul style="list-style-type: none"> Population health management will be at the core of commissioning and design of CYP-MH services, in line with the IJRWG framework. There will be an agreed process for inter-lead commissioning and service design, informed by current health data and anticipated population needs across the system and for identified groups.

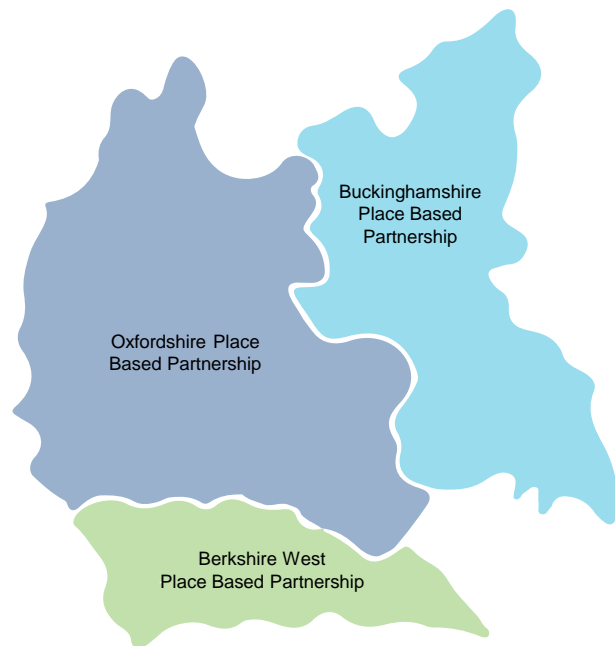
DRAFT – WORK IN PROGRESS

JFP – Emerging JFP Content on Place

Our model for system working has thriving places at its heart. As an ICB we want to empower, support and challenge our places to deliver for the people they serve. Decisions about the delivery of services are 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 in particular places. So this Joint Forward Plan will be delivered in partnership with leaders and staff working closely with our population at every level – be this 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 local Health and Wellbeing strategies, and in conjunction with the Health & Wellbeing Boards. 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.

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 detailed Target Operating Model which will define how accountability and responsibility 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.

JFP timescales

JFP Timeline

- Formal Publication is required by: **30 June 2023** (published and shared with NHS England, the Integrated Care Partnership (ICP) and HWBs)
- First version to be produced by **31 March 2023**

Engagement Requirements

- The plan will be developed with NHS Trusts
- It is a statutory requirement that we engage across the system on the JFP incl.
 - Primary care,
 - Local Authorities and relevant HWBs,
 - VCSE sector,
 - People and communities

Sign Off

- ICB and Trust Boards are expected to formally review and approve the JFP in late April – May 2023
- Each of the five Health and Wellbeing Boards will be given opportunity to review and provide a formal opinion '*on whether the draft takes proper account of local health and wellbeing strategy*' in June 2023 prior to publication – The opinion will be published with the JFP.
- In future years, ICBs and their partner trusts will have a duty to update their JFP before the start of each financial year – i.e. by **1 April**.

Our JFP Engagement Approach

Engagement Level	Purpose and Timing
BOB networks	<p>Engagement through ICB Planning Leads to develop and refine service-level content (<i>Ongoing, supported by weekly calls</i>). Through the Planning Leads, service level plans continue to be reviewed and iterated through engagement with the relevant System Networks as required –e.g. elective care board, UEC Programme Board, integrated cardiac delivery network.</p> <p>Engagement with the Operational Planning team to ensure consistency and alignment (<i>Ongoing, supported by weekly calls</i>)</p> <p>Updates to the ICB Executive Team (<i>fortnightly</i>) and ICB Board (<i>21 February</i>) on progress, emerging content and direction of travel.</p>
NHS Trust	<p>Engagement with Provider Strategy Directors to share and test emerging content – particular focus on agreement of System Priorities (<i>Ongoing</i>)</p> <p>Updates to the Provider Executive Teams, through the Strategy Directors (TBC), to share and test content on priority areas (<i>March</i>)</p>
Place	<p>Place Executive Groups (<i>3 March – 30 March</i>) and Health and Wellbeing Boards (16 – 30 March) where possible to update on progress, share emerging content where relevant to the role of Place in JFP, link to JLHWS, link to ICP Strategy</p> <p>Engagement with Place Directors (<i>ongoing</i>) on ensuring the role of Place is appropriately represented in the JFP</p>
System Partners	<p>Liaison with VCSE alliance and Healthwatch to agree sharing and input into JFP from VCSE sector and community/patient representatives (<i>March</i>)</p> <p>System Workshop (<i>24 March</i>) – System-wide participation to share progress, test ambition and build opportunities for partnership</p>
Regional	<p>Liaison with NHS England to agree how NHSE can support with the development of the plan, visibility of an early draft of the JFP, agreement on development process and how NHSE are involved going forward (<i>7/8 March</i>)</p>