Better Care Fund planning template – Part 1

Please note, there are two parts to the template. Part 2 is in Excel and contains metrics and finance. Both parts must be completed as part of your Better Care Fund Submission.

Plans are to be submitted to the relevant NHS England Area Team and Local government representative, as well as copied to: NHSCB.financialperformance@nhs.net

To find your relevant Area Team and local government representative, and for additional support, guidance and contact details, please see the Better Care Fund pages on the NHS England or LGA websites.

1) PLAN DETAILS

a) Summary of Plan

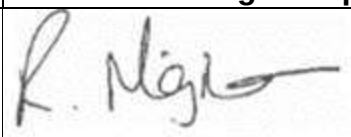
Local Authority	**Oxfordshire County Council**
Clinical Commissioning Groups	**NHS Oxfordshire Clinical Commissioning Group**
	NHS Swindon Clinical Commissioning Group
	NHS Aylesbury Vale Clinical Commissioning Group
Boundary Differences	**Thame, Shrivenham – addressed by sharing plan with relevant CCGs (Aylesbury Vale CCG and Swindon CCG respectively) for these areas and ensuring equity of delivery across the county as a whole**
Date agreed at Health and Well-Being Board:	**13 March 2014**
Date submitted:	**4 April 2014**
Minimum required value of ITF pooled budget: 2014/15	**£10,503,000.00**
2015/16	**£37,574,000.00**
Total agreed value of pooled budget: 2014/15	**£10,503,000.00**
2015/16	**£37,574,000.00**

b) Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	**NHS Oxfordshire Clinical Commissioning Group**
By	

	 Dr Joe McManners
Position	Clinical Chair
Date	3 April 2014

Signed on behalf of the Clinical Commissioning Group	**NHS Swindon Clinical Commissioning Group**
By	 Caroline Gregory
Position	Chief Finance Officer
Date	4 April 2014

Signed on behalf of the Clinical Commissioning Group	**NHS Aylesbury Vale Clinical Commissioning Group**
By	 Robert Majilton
Position	Chief Finance Officer
Date	02 March 2014

Signed on behalf of the Council and the Health and Wellbeing Board	**Oxfordshire County Council**
By	Cllr Ian Hudspeth 
Position	Leader of the Council and Chairman of Health and Wellbeing Board
Date	2014

c) Service provider engagement

Please describe how health and social care providers have been involved in the development of this plan, and the extent to which they are party to it

Oxfordshire County Council and the Oxfordshire Clinical Commissioning Group already have well established and effective working relationships, and an ongoing commitment to further integrate services to ensure all the available funding is used to best effect, improves quality and improves outcomes for service users / patients and carers.

The Council and the Clinical Commissioning Group have worked together in establishing strong governance arrangements, including the Health and Wellbeing Board and Joint Management Groups overseeing the pooled budgets that engage commissioners, GPs, clinicians, providers and service users / carers in decision making. In addition, Oxfordshire has had an effective Urgent Care Working Group in operation since 2012 with membership from Oxfordshire Clinical Commissioning Group (OCCG) Oxfordshire County Council (OCC) Oxford University Hospitals NHS Trust (OUHT), Oxford Health and South Central Ambulance Service (SCAS)

Specifically Oxford Health have played a key role in shaping some of the proposals in this plan, as we have already been working with them as a key delivery partner for locality based integrated teams, shared care coordination and shared data

Social care providers have been involved in the development of the plan through their roles on the Older People's Partnership Board, and as part of the full and wide consultation / engagement activity to develop the Joint Older People's Commissioning Strategy that underpins the proposals for this Fund.

The plan will be shared widely with providers once agreed, as they will have a key role in shaping the proposals further and ensuring they are implemented successfully.

d) Patient, service user and public engagement

Please describe how patients, service users and the public have been involved in the development of this plan, and the extent to which they are party to it

Service users are represented on the Older People's Joint Management Group and the Older People's Partnership Board, both of which have been involved in developing the proposals and will have roles in implementation.

An additional workshop was held with representatives of older people, learning and physical disability, mental health and carers to discuss and develop proposals.

There was full and wide consultation as part of developing the Joint Older People's Commissioning Strategy that sets the context for the proposals in this plan. This included online consultation, focus groups, workshops with a wide representation of older people and providers, and a reference group comprised of and chaired by older people alongside commissioners.

This plan also aligns closely to the Oxfordshire Clinical Commissioning Group 5 Year Strategic Plan, that was subject to public consultation in late 2013.

e) Related documentation

Please include information/links to any related documents such as the full project plan for the scheme, and documents related to each national condition.

Document or information title	Synopsis and links
Health and Wellbeing Strategy 2012-2016	**https://www.oxfordshire.gov.uk/cms/sites/default/files/folders/documents/aboutyourcouncil/plansperformancepolicy/oxfordshirejointhwbstrategy.pdf**
Joint Older People's Commissioning Strategy 2013-2016	**http://www.sourceoxfordshire.org.uk/cms/sites/source/files/folders/documents/OlderPeoplesJointCommissioningStrategy.pdf**
Adult Social Care Business Strategy 2014/15 – 2017/18	**http://mycouncil.oxfordshire.gov.uk/documents/s24264/Section%203.pdf (see pages 21-39)**
Section 75 for all client groups	**Attached**
Existing S256 Transfer Agreement	**Attached**

2) VISION AND SCHEMES

a) Vision for health and care services

Please describe the vision for health and social care services for this community for 2018/19.

- What changes will have been delivered in the pattern and configuration of services over the next five years?
- What difference will this make to patient and service user outcomes?

The current vision for Oxfordshire through to 2018/19 is that articulated through the Oxfordshire's Joint Health and Wellbeing Strategy 2012-2016, Adult Social Care Business Strategy 2014/15-2017/18 and the Clinical Commissioning Group's five-year strategic plan:

i. More children and young people will lead healthy, safe lives and will be given the opportunity to develop the skills, confidence and opportunities they need to achieve their full potential
ii. More adults will have the support they need to live their lives as healthily, successfully, independently and safely as possible, with good timely access to health and social care services
iii. Everyone will be given the opportunity to voice their opinions and experiences to ensure that services meet their individual needs
iv. The best possible services will be provided within the resources we have, giving excellent value for the public
v. Be delivering fully integrated care, close to home, for the frail elderly and people with complex multi-morbidities.
vi. Have a primary care service that is driving development and delivery of this integrated care, and is itself offering a broader range of services at a different scale.
vii. Support choice and control in the belief that people themselves, regardless of age or ability, are best placed to determine what help they need.
viii. Routinely enable people to live well at home and to avoid admission to hospital when this is in their best interests.
ix. Be continuing to provide preventative care and to tackle health inequalities for patients and carers in both its urban and rural communities
x. Be providing health and social care that is rated amongst the best in the country for all its citizens in terms of quality, outcomes and local satisfaction with services

Oxfordshire County Council and the Oxfordshire Clinical Commissioning Group already have well established and effective working relationships, and an ongoing commitment to further integrate services to ensure all the available funding is used to best effect, improves quality and improves outcomes for service users / patients and carers.

The Council and Clinical Commissioning Group have worked together in establishing strong governance arrangements, including the Health and Wellbeing Board and Joint Management Groups overseeing the pooled budgets that engage commissioners, GPs, clinicians, providers and service users / carers in decision making.

Over £330m is currently committed to pooled budget arrangements across all client groups, representing a third of Clinical Commissioning Group resources and 99% of adult social care funding. This includes a significantly expanded pool covering care for older people, and others to improve care and outcomes in physical disability, learning disability and mental health and wellbeing. .

We have joint commissioning strategies that set out our shared intentions and mature risk sharing arrangements that mean we have truly pooled budgets, that in the case of older people we believe this to be unique in the country. Existing pooling of funds is being used to protect adult social care services by paying for the discharge to home service, increase spending on equipment and meeting an increased number of home care packages in response to the demographic challenges.

We are working together to implement an outcomes based contract for services for older people; in 2014/15 we are targeting the acute assessment/admission/discharge / reablement pathway incorporating both community and acute health services. Given our pooled budget arrangements we are working together to determine whether it makes sense for some social care funded services to be incorporated in this approach and are making positive progress.

- In order to support the Clinical Commissioning Groups vision of patient-centred high quality care, which is integrated, cost effective and efficient, it is proposed that the CCG and the County Council work together to join up commissioning and integrate the provider services for the benefit of patients.

- The key points where organisations will join up to deliver the most benefit to people are in the commissioning of services, in individual assessment and in care co-ordination, leading to a coordinated and seamless response to need at both a population level and at an individual level.

We will committed to exploring whether:

- The CCG and the Council create a Joint Commissioning Unit for management of the pooled budget.
- A single assessment process is implemented
- Community providers including GPs integrate to deliver care co-ordination.

Following assessment, where people need ongoing care and support, a diversity of health and social care service provision will be maintained to facilitate choice, innovation and sustainability.

Under the leadership of the Health & Wellbeing Board, joining up commissioning will mean that commissioners in the CCG and the local authority will develop shared vision, plans and pooled budgets. This creates the opportunity to design coherent, reliable and efficient patient pathways, and ensure the incentives are right for providers to provide interoperable services within these pathways. We will share best practice, expertise and intelligence about needs.

The benefits of joint commissioning are that it will help to:

- Target services to give the greatest impact on outcomes
- Share expertise and best practice
- Share intelligence on needs in a systematic way

- Break down silos and gaps between healthcare and social care
- Co-ordinate services by encouraging providers to work together (and with commissioners).
- Produce financial efficiencies by reducing duplication and focusing on value for money for every pound spent.
- Effective and efficient ways of planning leading to major service transformation.

Provider Integration

It is proposed that the Council front line social work and occupational therapy teams join up with the community provision delivered by Oxford Health. GPs, hospitals, health workers, social care staff and others will work side-by-side, sharing information and taking a more coordinated approach to the way services are delivered. At the moment, if someone needs to arrange care from a district nurse, for example, but also needs help to bathe or prepare a meal, they might have two or three different professionals arriving at their door and asking similar questions before help can be put in place. This will be replaced by a single assessment process that is controlled where possible by the patient and reduces unnecessary duplication.

With these changes, the process will become much smoother. Staff such as district nurses, community matrons, social workers and other professionals will be in a position to communicate with each other on a regular basis and share information to support people better. Some patients will have a single care coordinator who is their main contact point.

Staff from all sides can more easily identify which patients are most at risk – for example, of going into hospital – and then put together a combined package of care, support and lifestyle advice designed to keep them healthier and independent for longer. If someone ends up in hospital, staff from the hospital can work with those in the community to help them leave with the right support in place. Joint working will:

- help to get rid of out of date processes that are duplicated across both health and social care
- reduce waste and bureaucracy by working as a more efficient, combined unit
- minimise delays in care and give people the right support at an earlier stage so they are less likely to experience worsening of their condition
- reduce the need to go into hospital and enable people to better manage their condition and live as independently as possible
- improve the sense that services are 'fragmented' by reducing the number of professionals that need to be involved in one person's care, and ensuring those who do are working more closely together.

b) Aims and objectives

Please describe your overall aims and objectives for integrated care and provide information on how the fund will secure improved outcomes in health and care in your area. Suggested points to cover:

- What are the aims and objectives of your integrated system?
- How will you measure these aims and objectives?
- What measures of health gain will you apply to your population?

Our approach will be based on furthering the aims and objectives in Oxfordshire's Joint Health and Wellbeing Strategy 2012-2016 and the Clinical Commissioning Group and Oxfordshire County Council Older People's Commissioning Strategy 2013 – 2016. Both of these are based in part on the Joint Strategic Needs Assessment and were developed in partnership with wide partner and user engagement.

The Joint Health and Wellbeing Strategy includes the following priorities for adults:

- Living and working well: Adults with long-term conditions, physical disabilities, learning disabilities or mental health problems living independently and achieving their full potential
- Support older people to live independently with dignity whilst reducing the need for care and support
- Working together to improve quality and value for money in the Health and Social Care System

There are 6 priorities in the Older People's Commissioning Strategy, which are shaped to reflect the patient voice and experience – these seek to achieve the following outcomes:

1. I can take part in a range of activities and services that help me stay well and be part of a supportive community.
2. I get the care and support I need in the most appropriate way and at the right time.
3. When I am in hospital or longer term care it is because I need to be there. While I am there, I receive high quality care and am discharged home when I am ready.
4. As a carer, I am supported in my caring role.
5. Living with dementia, I and my carers, receive good advice and support early on and I get the right help at the right time to live well.
6. I see health and social care services working well together.

These also have resonance across all client groups, so although the focus will be primarily on older people there will be wider benefits for all – particularly when combined with other funding streams in the Better Care Fund that protect existing spending on Disabled Facilities Grants and carers breaks.

In keeping with the aims in the Oxfordshire Clinical Commissioning Group Five Year Strategy, the need for our patients is to have joined up care that provides better care at home and reduces unnecessary time spent in hospitals and care homes. It will;

1) Deliver joined up health and social care to the frail elderly, patients with multi-morbidities (particularly the top 2% of cost risk), patients with physical and mental health needs (including those with dementia), and patients on the palliative care register.

2) Deliver anticipatory care plans and care co-ordination when unstable for those patients.

3) Develop locality based 'hubs' that are community facing and offer rapid access, multi-disciplinary team assessment for diagnosis and care planning (see below)

4) Move to acute hospital stays that are as brief as needed, so the patient moves to the most appropriate place as soon as possible without delay

5) Help primary care develop to work better together and improve joint working with community, social care and secondary care.

6) Develop the primary care provider community so that GP services can contribute and potentially lead integrated care services

7) Have named social and community healthcare link workers assigned to each general practice

8) Have clearly defined roles and responsibilities within urgent and emergency care pathways

9) Delivery of a new jointly commissioned service model that delivers shared outcomes for patients across the system

10) Provide 7 day working in health and social care

The current priorities in the Oxfordshire's Health and Wellbeing Strategy already include a focus on the national measures required by the Better Care Fund (see below) – these indicators are also included in the Older People's Commissioning Strategy and will be used to measure how effectively we achieve the aims and objectives given above:

Better Care Fund Metric	**Local Metric**
Admissions to residential and care homes	Reduce the number of older people (aged 65 and over) per year permanently admitted to a care home (Health and Wellbeing Strategy indicator 6.5)
Effectiveness of reablement	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services (This will be added as a Health and Wellbeing Strategy indicator for 2014/15 onwards)
Delayed Transfers of Care	Reduce the number of delayed days for transfer or discharge from hospital (This will be added as a Health and Wellbeing Strategy indicator for 2014/15 onwards)
Avoidable Emergency Admissions	Reduce the number of emergency admissions to hospital for older people aged 60+ (Health and Wellbeing Strategy indicator 6.3)
Patient / Service User Experience	Achieve above the national average of people very satisfied with the care and support they receive from adult social care (Health and Wellbeing Strategy indicator 7.3) Achieve above the national average of people satisfied with their experience of hospital care (Health and Wellbeing Strategy indicator 7.4) Achieve above the national average of people 'very satisfied' with their experience of their GP surgery (Health and Wellbeing Strategy indicator 7.5)
Locally determined	

measure: People with high level care and support needs supported to live at home	Increase the proportion of older people (aged 65 and over) with an ongoing care package supported to live at home (Health and Wellbeing Strategy indicator 6.7)	

c) Description of planned changes

Please provide an overview of the schemes and changes covered by your joint work programme, including:

- The key success factors including an outline of processes, end points and time frames for delivery
- How you will ensure other related activity will align, including the JSNA, JHWS, CCG commissioning plan/s and Local Authority plan/s for social care

We are in a strong position to build on our existing relationships and joint working that has seen us develop (for example) integrated locality teams, a single point of access for health and social care, and Winter Pressures pilots in winter 2013-14 - the evaluation of which will inform an overall model of integration. We have also initiated the South East GP pilot that provides an Adult Social Care Link Worker in six GP practices to share information, signpost and discuss appropriate care for high risk patients requiring both health and social care services.

However, we also recognise the need to do more to address the increasing number of frail older people as the most significant challenge that faces health and social care in the county. There are increasing demands for care from a relatively small proportion of the population. Financial resources are not increasing in line with those demands so we need to focus on intervening early and quickly to limit the extent to which care needs increase.

We also need to do more to address key areas of under-performance, notably the number of people who are admitted to hospital when they didn't need to be and the number who spend longer in hospital than they need to. Although there are relatively few people placed in care homes in Oxfordshire compared to other areas, we want to reduce this further still.

It is proposed that the Better Care Fund is used to protect services in adult social care where there is a clear benefit to the wider health and social care sector and contribution to reducing activity/costs in acute health care, as defined by the aims of the Joint Older People's Commissioning Strategy and the nationally determined metrics for the Better Care Fund. There will be an emphasis on ensuring the right care in the right place, first time, and the vital links between intermediate community care and hospitals.

Through the mechanism of the pooled budgets we will continue to move resources between health and social care to spend on those services which have greatest impact on the demand for health and social care, including bed-based care in particular.

These proposals have been developed in response to the priorities identified in Oxfordshire's Joint Health and Wellbeing Strategy, which is based on the highest priorities for action identified through the Joint Strategic Needs Assessment. This has identified demand for social and health care, particularly from an increasing number of

frail older people, as the most significant challenge facing the county – and this is reflected in the financial and strategic plans of both the Clinical Commissioning Group and the County Council.

Proposals are therefore designed to build on the existing commissioning and activity happening across the health and social care system, individually and collectively amongst partner organisations and providers. A proportion of the funding is already being utilised as part of the existing transfer from health to social care on a range of preventative measures to support people to live independently in their own home for as long as possible. This includes a range of home support packages, equipment and assistive technology, crisis response services, reablement, and carers breaks. All these will continue from 2014 onwards. We will also continue to invest in meeting increased demand across social care and health (including Funded Nursing Care and Continuing Healthcare), and make sure that resources are focused on care in the community rather than in hospitals.

The Better Care Fund will also include capital funding currently used by District Councils to support adaptations to property to support people to stay at home (Disabled Facilities Grants) and additional capital funding used by adult social care to support Extra Care Housing schemes. These will continue to be funded at the same levels as currently, as there is evidence that these are effective in supporting the ambitions in this plan and meeting aims of the Fund.

Adult social care is preparing for the implementation of the Care Bill from April 2015 onwards, and a proportion of the funding within the Better Care Fund is assumed to support this. In particular it will be used to support improved information and advice, including for self-funders, and for improved IT systems to support management and tracking of care accounts once funding details are finalised.

There are also a number of proposals that will be delivered from April 2015 onwards that both support / protect adult social care and will bring reduced activity and costs in the acute sector. These flow across the whole health and social care pathway:

- **Information and advice**
  The provision of good quality information and advice is critical in enabling people to make best use of their resources, empowering and enabling people to assess and then take control of their own support needs and to use information on the quality of provision to make informed choices about their lives.

  We will invest in a new online marketplace for care, building on existing systems to enable people to people to resolve their own problems. This will provide people with a menu of options for how their needs could be met, along with prices, and allow them to choose between without the need for the Council to broker the service. The service will provide real time quality feedback and ratings, and real time availability of care with the ability for providers to upload and maintain their own information.

- **Equipment and assistive technology**
  There is extensive evidence that the use of equipment and assistive technology is an effective way to support independence and allow people to live at home for longer. We will continue to invest in this as an alternative to residential and domiciliary care provided by care workers where suitable.

There is also evidence that this can help reduce admissions and represent savings in the wider system. A recent review showed that over 30% of calls to the emergency services for clients of the Alert Service in Oxfordshire (a countywide service providing telecare alarm equipment to vulnerable and older adults) were handled by a mobile responder rather than needing to refer for an ambulance. This equates to a saving of over £300k per year, plus avoiding further costs for the NHS had the users been admitted to hospital.

- **Create a more personalised approach to home support which will include removing short visits for personal care for older people**

  We will ensure that no home care visit offering personal care is too short for the person to be treated with dignity and respect. Often home support for older people has become too focused on time and task, as opposed to good outcomes for the person. Sometimes visits are too short for the person to be treated with dignity and respect. We will link this funding to an improvement in performance for home support based on the needs of the older person.

  We will continue to invest in new approaches to providing domiciliary care. We will develop a mainstreaming approach that builds reablement into all home care provision rather than seeing it as a separate service.

  We will ensure seven day working in social care and amongst providers of services to avoid the need for hospital admissions at weekends that would be avoided during the week, support effective discharge from hospital, and improve pick up times in intermediate community care.

  We will implement Individual Service Funds that promote a more personalised approach to home support. Home support providers will receive the Individual Service Fund directly from the local authority and work with the older person to organise their care based on a support plan. Individual Service Funds have the benefit of reducing the number of short visits and improving the experience of both the older person and the home support worker – thus they will have a positive impact on both outcomes (including pick up times) and workforce. While they require up-front investment in systems and training, there is potential to save money in the long run.

  We will implement changes over a two year period from October 2014 onwards, to allow time to work with providers to affect any changes that are needed in the range of services or how they operate.

- **Integrated support for hospital admission avoidance**
  Linked to personalisation of home care, we will fundamentally review the provision and accessibility of community services provided across health and social care that support people outside of hospital. This will support our ambition to support people as close to home as possible, and ensure that the right services are available in the local area to enable this.

  We will also invest in improving a range of community-based services that reduce emergency admissions of vulnerable and frail older people by supporting them at home, and to return home as soon as possible after an admission. This will include further development of emergency multidisciplinary assessment pathways, to ensure appropriate medical, nursing, social and therapeutic capabilities in both acute and

community sectors.

We will develop primary care services to enable better management of complex patients with multiple-morbidity/frailty. These services will provide enhanced medical and nursing support for these patients and will work with integrated health and social care teams on localised populations based around GP practice populations.

We will focus on reducing the number of repeat admissions, Accident and Emergency attendances and primary care attendances for younger adults with high needs, often as a result of mental health problems or drug/alcohol dependency. The cost of supporting this relatively small number of individuals is disproportionately high, and investment in services across public health, social care and primary care to address the underlying causes of these admissions will reduce costs and improve outcomes for these individuals.

We will also invest to improve the quality and range of medical and nursing services for care homes through our Quality in Care homes programme, ensuring that residents benefit as much from the development of modern integrated services as people still living in their own home. This is currently being developed into a business case for organisational approval.

We will work to broaden the role of GPs in supporting and delivering a whole systems approach, having input along the whole pathway as with interface medicine capability. This will include the development of an agreed vision and five year strategy for the development of primary care in Oxfordshire which addresses the role of GP practices in:

i. Providing more proactive coordination of care, particularly for people with long term conditions including dementia

ii. Providing more holistic, integrated care in the community

iii. Ensuring fast, responsive access to urgent care needs

iv. Preventing ill health, including more timely diagnosis and early identification of people at greatest risk of becoming unwell

v. Involving patients and carers more fully in their self care

vi. Ensuring high quality care, in particular the patient experience

We will also produce and support the delivery of a plan which articulates the preferred function and form of federated working in Oxfordshire so that primary care is in a position to:

i. Enter the market as a provider of services operating at scale across the county

ii. Develop more innovative and integrated primary and community services which deliver improved access and increased continuity of care

iii. Support effective urgent and emergency care pathways

iv. Address health inequalities more effectively in both urban and rural areas in order to support GPs to increase their role in driving development and delivery of

integrated care in the community, the leadership capacity of primary care will be developed so that leaders are identified and supported to act as strategic partners in provider discussions around changes in service delivery. This will ensure that primary care views are clearly voiced and considered in any system level change.

- **Investment in Carers Breaks jointly funded and accessed via GPs**
  Carers already play an essential role in the development of health and social care services in Oxfordshire. 61,131 of Oxfordshire's residents (9.4% of the population) provide some unpaid care to family or neighbours with ill health or disability.

  There will be continued investment to support family carers, further investment to build on the existing success of carers breaks (where demand exceeds budget) as well as training and support for carers, and intensive support for carers when the person they care for is in hospital.

- **Support to people with dementia**
  We will invest further in supporting people with dementia, building on improved rates of diagnosis and recognising the increased numbers of older people living with the condition. This will be a theme running through a number of the proposals, including targeted training for home care providers to ensure their staff are trained in recognising and supporting people with dementia living in the community.

  We will also build capacity to support people with dementia in nursing homes, including block purchasing beds that are developed to reflect the learning from existing work to create more dementia-friendly environments in health and social care settings. We will also work with the Order of St John to increase their capacity to provide specialist dementia care in care homes, and with other providers to encourage them to do the same.

- **Reablement and rehabilitation**
  The Council will focus on improving the key first response services such as crisis response and reablement. We will also work with the Clinical Commissioning Group to develop multi-disciplinary, integrated front end services that include key clinical inputs such as nursing and therapy as part of the service model.

  Through locality and outcome based contracts we will offer seamless "one stop shop" solutions for crisis, rapid response and enabling support at home which respond more effectively to the needs individual service users to move between service functions without hand-offs between providers. It will also help meet the needs of the wider social and health care system by reducing duplication and improving coordination of care across agencies.

  We will significantly grow the capability of the domiciliary care market to deliver effective enabling care, by working with providers to identify, develop and train care workers to deliver care that restores and enables people to maintain their independence.

- **Support for people to die at home / in residential care**
  Oxfordshire's joint strategy for end of life care aims to improve the quality of end of life care and support more people to die in their place of choice, which will often be in their own home or place of residence. The integration, capability and responsiveness

of social care services is essential for ensuring that people receive the holistic and humane support that they need at the end of their lives, and that family carers are supported both before and after someone dies.

The Council will continue to support OCCG in developing and delivering the end of life care strategy for Oxfordshire, and will lend practical support to the strategy through a range of initiatives. Particular emphasis will be on working with care providers to ensure that care workers and family carers are trained to recognise and supported to respond to the needs of people who are dying. We will also clarify guidance for service users with an end of life diagnosis and their family carers on the support available to them.

d) Implications for the acute sector

Set out the implications of the plan on the delivery of NHS services including clearly identifying where any NHS savings will be realised and the risk of the savings not being realised. You must clearly quantify the impact on NHS service delivery targets including in the scenario of the required savings not materialising. The details of this response must be developed with the relevant NHS providers.

Oxfordshire recognises the need for full alignment of plans across the whole health and social care system. As such we are committed to the principles of long term sustainability for the system as a whole which delivers best outcomes for its population within a challenged resource envelope.

The Clinical Commissioning Group and County Council as co-commissioners, along with our key acute provider Oxford University Hospitals Trust, are considering how best to ensure:

Good governance of the Better Care Fund and in particular the role of the Joint Management Group for Older People in identifying and managing the risks of reliance upon reduction in acute activity to pursue developments through the Better Care Fund
Good programme oversight of the initiatives set out in the Better Care Fund plan and in particular the role of the Whole Systems Programme Board in ensuring that, when taken as a whole with the work streams of the Older People's Programme and the Urgent Care Improvement Plan, the Better Care Fund initiatives are complementary to the remainder of the work on the urgent care pathway
Production of high quality business cases for the initiatives in the Better Care Fund so that they demonstrate 'clear benefits to the wider health and social care sector and reduce costs in acute health care' and their subsequent monitoring and evaluation and where and how they are best signed off.

Commissioners are currently awaiting an integrated proposal from providers on the development of an older people's pathway on an outcomes basis. Given the interdependence between the Better Care Fund Plan, this proposal and the risk of non-realisation of the necessary savings in the acute sector to support the plan; and given that this risk related principally to 2015/16, the work to agree the above arrangements has been scheduled to be completed in the first quarter of 2014/15.

e) Governance

Please provide details of the arrangements are in place for oversight and governance for progress and outcomes

Implementation of the Better Care Fund plan will be overseen by the various organisational governance structures, reporting to the Health and Wellbeing Board and constituent Clinical Commissioning Group and County Council.

The Older People's Joint Management Group meets in public bi-monthly, and has a key role contributing to the delivery of the priorities in the Joint Health and Wellbeing Strategy by monitoring and managing the implementation of the Joint Older People's Commissioning Strategy through the Older People's Pooled Budget, including and performance indicators, activity and spending. It reports regularly and by exception to the Health and Wellbeing Board and Clinical Commissioning Group and County Council.

The Joint Management Group comprises senior officer and member representatives of the County Council and Clinical Commissioning Group, as well as District Councils, health providers, and service user representatives. It is supported by an Older People's Partnership Board that comprises wider representation from service users and providers, that has an advisory role to the JMG, and a Commissioning and Finance officer group that meets monthly to manage and monitor implementation, activity and spending.

3) NATIONAL CONDITIONS

a) Protecting social care services

Please outline your agreed local definition of protecting adult social care services.

We define protecting adult social care as prioritising the services that have the biggest impact on meeting the shared need to reduce demand for health and social care services by ensuring high quality, joined up services that support people to live independent and successful lives for as long as possible.

Please explain how local social care services will be protected within your plans.

Pooled funding will be used to protect services in adult social care where there is a clear benefit to the wider health and social care sector and contribution to reducing activity/costs in acute health care, as defined by the aims of the Joint Older People's Commissioning Strategy and the nationally determined metrics for the Better Care Fund. There will be an emphasis on ensuring the right care in the right place, first time, and the vital links between intermediate community care and hospitals.

Through the mechanism of the pooled budgets we will continue to move resources between health and social care to spend on those services which have greatest impact on the demand for health and social care, including bed-based care in particular.

b) 7 day services to support discharge

Please provide evidence of strategic commitment to providing seven-day health and social care services across the local health economy at a joint leadership level (Joint Health and Wellbeing Strategy). Please describe your agreed local plans for

implementing seven day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends.

We are committed to delivering 7 day access to health and social care services, and have already implemented 7-day working across a number of elements of the health and social care system. This includes social work teams in hospitals, covering wards and all front doors (Accident and Emergency, community and acute hospitals, and Emergency Medical Units). We have also incentivised social care providers to pick up clients within 72 hours, including Fridays and over the weekend. The Emergency Duty Teams also ensure there is support available 24 hours a day, 7 days a week.

This will be developed further in accordance with the improvement intervention and principle of resource maximisation, and as part of our commitment to shared care coordination.

c) Data sharing

Please confirm that you are using the NHS Number as the primary identifier for correspondence across all health and care services.

See below

If you are not currently using the NHS Number as primary identifier for correspondence please confirm your commitment that this will be in place and when by

Oxfordshire County Council are working with Oxford Health to ensure we are able to use the NHS number as the primary identifier for health and care services by April 2014, and this will be built into routine processes from then on.

Please confirm that you are committed to adopting systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK))

We are already working with health colleagues to ensure our respective tender processes for the SWIFT (Adult Social Care) and RIO (Health) replacements are aligned. Integration requirements have been appropriately specified within both statement of requirements.

Please confirm that you are committed to ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, professional clinical practise and in particular requirements set out in Caldicott 2.

Appropriate Information Governance controls are broadly in place for information sharing in line with Caldicott 2. We will undertake further work to build these controls into all training materials, and ensure they are included in work already underway to communicate new information governance policies and procedures to staff.

d) Joint assessment and accountable lead professional

Please confirm that local people at high risk of hospital admission have an agreed accountable lead professional and that health and social care use a joint process to assess risk, plan care and allocate a lead professional. Please specify what proportion of the adult population are identified as at high risk of hospital admission, what approach to risk stratification you have used to identify them, and what proportion of individuals at risk have a joint care plan and accountable professional.

Shared care coordination will form a key part of our commitment to establishing integrated health and social care providing patients, service users, GPs and acute service providers with a single, straightforward route to well joined up, locality based care. This will enable people to stay in their usual place of residence (or as close to it as possible)– for as long as possible, regardless of how many different community based health and social care specialists are involved in providing them with care

Oxfordshire County Council are working with the Clinical Commissioning Group, Oxford Health and primary care to establish an appropriate and efficient model of joint assessments and care planning, including an accountable lead professional for integrated packages of care. Pilot work is underway, targeting the patients within 5 localities with the highest levels of need and risk (including risk of unnecessary admission) and with particular focus on people with a diagnosis of dementia. This aligns with the emphasis in the new GP contract on the 2% of patients at highest risk.

A detailed model of service provision will be confirmed by all partners, using the outcomes of the pilot work to develop shared patient assessment and patient records, protocols and business processes which support the identification of the accountable lead professional, and 7 day service access.

In addition to dementia, this model of provision will also focus on individuals with co-morbidities, in recognition that the risk of admissions increases significantly for this group.

4) RISKS

Please provide details of the most important risks and your plans to mitigate them. This should include risks associated with the impact on NHS service providers

Risk	Risk rating	Mitigating Actions
Increasing demand for services could outstrip benefits accrued from planned schemes	High	Modelling of demand Close scrutiny of proposals and monitoring of implementation. Mature risk sharing.
Proposals are not effective in reducing demand, activity or spending in health and/or social care.	Medium	Close scrutiny of proposals and monitoring of implementation, appropriate remedial action to be taken
Proposals do not reduce the level of activity specifically in the acute sector and therefore allow the transfer of funds.	High	Routine monitoring of acute sector activity Involvement of acute sector on Health & wellbeing board, adult board and JMG

Financial pressures facing the system mean ambitions in plan cannot be implemented	Medium	Close scrutiny of proposals and monitoring of implementation, appropriate remedial action to be taken, open and transparent conversations
Market capacity may not increase in line with demand and appropriate levels of care are not forthcoming in the right place, at the right price and of the right quality	High	Production of market position statement giving clear signal to providers on how much care we expect to purchase Close working with providers in further development of community based care provision Agreeing a charter with clients and providers about care standards Reviewing new personalised home support contracts based on individual needs
Enough people will be willing to work in the health and social care sector at a time of increasing financial pressure for the sector, and in an area of high employment	High	Work with providers and others to develop a workforce plan for the county. Investment in workforce and training as part of Better Care Fund proposals (dementia, carers)