Integration and Better Care Fund

# Better Care Fund 2025-26 HWB submission

# Narrative plan template

| | HWB area 1 | HWB area 2 |
|---|---|---|
| **HWB** | Oxfordshire | n/a |
| **ICB** | Buckinghamshire, Oxfordshire and Berkshire West | n/a |
| **ICB** | Bath, North-East Somerset, Swindon and Wiltshire | n/a |

## Section 1: Overview of BCF Plan

This should include:

- Priorities for 2025-26
- Key changes since previous BCF plan
- A brief description of approach to development of plan and of joint system governance to support delivery of the plan and where required engage with BCF oversight and support process
- Specifically, alignment with plans for improving flow in urgent and emergency care services
- A brief description of the priorities for developing for intermediate care (and other short-term care).
- Where this plan is developed across more than one HWB please also confirm how this plan has been developed in collaboration across HWB areas and aligned ICBs and the governance processes completed to ensure sign off in line with national condition 1.

**Priorities for 2025/26 and key changes from 2024/25**

Oxfordshire has developed and delivered a Home First Discharge to Assess model of supporting flow through acute hospitals. In 2024/25 we have seen a reduction in average length of delay in all discharge pathways and 20% overall. The number of discharges per day have increased from =/- 12.5 to >16. We have achieved this while maintaining outcomes for individuals from reablement and continuing to reduce the number of people aged >65 placed by the Council in permanent residential settings. This activity is in-line with the local ambition to support people to live independently in their own community, identifying their own assets and maximising their own strengths.

This impact has improved outcomes for more individuals and delivered a reduction in bed occupancy in the main acute trust. The BCF funds our System UEC Commissioning Lead, the Transfer of Care manager, the system Home First Lead, the Home First teams, the pathway 2 hub team and has invested significantly in new models of home first reablement and care, including live-in care as well as redesigning the Pathway 2 step down reablement beds to meet the needs of a more complex patient population.

Oxfordshire now has sufficient capacity through its Live Well at Home and Care Home frameworks to deliver discharge flow and support ongoing independence in the community. Oxfordshire has become “good” at getting people home. This is extended to mental health beds where a range of BCF schemes have reduced the days lost to delay in acute mental


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health settings, and reduced the number of days people are placed out of county awaiting a bed in Oxfordshire.

Our priorities for 2025/26 are to ensure that more people can stay at home, living independently in their own communities and being supported in their own home should they have health crisis rather than being conveyed and admitted to acute hospital.

In 2025/26 Oxfordshire will continue to implement these preventative services that were commenced under Additional Discharge funding in 2024/25 and further develop the opportunities to align BCF with areas such as housing, public health and technology.

Our priorities for 2025/26 align with the system UEC plan and support NHS and Local Authority planning requirements:

- Further develop the community single point of access established in 2024/25 to co-ordinate community-based resources, to divert calls from the 999/111 stack into urgent community response, increasing home visiting nursing and intermediate care and to embed call before convey support to ambulance crews. We need to develop a "community TOC" capability.
- Implement and extend urgent community response into a wider home visiting service and MDT at neighbourhood level. This will further integrate hospital at home, community same day emergency care, community therapy, voluntary and community capacity, and specialist mental health and children's and young people's support to support reduction of non-elective admissions
- Focus on readmissions and care homes to avoid unnecessary conveyance and admission to hospital. We will review our Pathway 1 model to assure that the appropriate levels of community support in addition to reablement and homecare are in place to avoid readmission, and we will review our support to care homes where medical support may be needed to avoid an escalation to acute hospital
- Continue to invest in services that address health inequalities and avoid admissions
    - Focus on locality community responses to those areas of deprivation that drive non-elective admissions, especially in relation to people aged 50-64 with diseases of aging in deprived areas of Oxfordshire
    - Provide support and alternatives to admission for people living with learning disability and/or autism who are at risk of admission to mental health beds
    - Provide step up support through dedicated homelessness pathways, support around alcohol and support for the most complex high intensity users to divert them from Emergency Departments and risk of admission to community support


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    - Develop responses for children and young people especially around mental health and respiratory presentations where there is an alternative to admission

- These priorities reflect the approach taken in the system UEC plan which is focussed on reducing non-elective bed days lost through admission and through discharge day delays. The BCF plan will also support the acute provider in managing out of area admissions and delays which are a significant pressure and impact on the response to Oxfordshire patients, especially in the north of the patch at Horton General Hospital

- Together these plans are aimed at reducing NEL admissions and NEL bed day consumption for General Medicine and Geratology patients back to 2023/24 baseline. This recognises the need to control activity and costs across the system and develop approaches that might move resources from acute to community in the medium and longer term.

The BCF plan will also continue to underpin the wider community and strengths based preventative approach set out in the *Oxfordshire Way.* We will continue to expand community reablement and improve the alignment with community rehabilitation as part of our plan for intermediate care. We will be implementing a new contract to deliver technology-enabled care as a development of the current telecare offer and maximising the opportunity to divert people to falls prevention and other support that enables independence and resilience. We will continue to invest in support for people at risk of falls and divert them wherever possible into community "strong and steady" services delivered by partnerships between community health and voluntary sector providers.

We will align the BCF funded community information, advice and support offer with the community capacity that is being developed outside of the Better Care Fund: Local Area Co-ordination and Community Capacity Grants funded by Adult Social Care; Well Together support and grants funded by Public Health and the ICB Health Inequalities funds working in the most deprived areas; community wellbeing workers aligned to primary care; support around activity and loneliness through the wider community and working closely with NHS Social Prescribing and District Council neighbourhood resources. Oxfordshire is developing a wider Prevention Strategy that will be implemented in 2025/26 and will improve our ability to map and evidence the impact of preventative activity on the BCF and other system metrics. We also plan to bring more of the prevention funding into local s75 arrangements to develop further the integration of these approaches.

We continue to develop services for unpaid carers as part of the key underpinning of the plan and to support prevention and our ability to support people at home. Oxfordshire has a system wide Carers Strategy and the key providers across health (including primary care) and social care have schemes to improve the identification and support to unpaid carers such as carers ID cards. We have engaged with carers in 2024/25 as part of the review of Home First Discharge to Assess carried out by Healthwatch Oxfordshire and identified key learning.


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One gap in our current plan is support to self-funders. Review of Oxfordshire performance on permanent admissions to care homes has highlighted that >35% of people who become council funded placements were already in their care home at that point. In most cases they can no longer be supported in an alternative environment but in many cases, they are long-term residents who may not have needed this level of care when they self-admitted. We are beginning a programme of work to create publicity and offer support to people where there may be alternatives to care homes (e.g. extra care housing). In 2025/26 we have an opportunity to promote and develop our approaches through a new extra housing scheme that will come on board in October 2025.

Our other key aim for 2025/26 is to fully evaluate key schemes that have potential to underpin the aims of the BCF going forward:

- We will work with the City and Districts on a review of homelessness services including the Health and Housing Intervention Team funded by BCF; the Homelessness Alliance pathways part-funded from BCF; and the wider District and City and Public Health funding for rough sleeping. This work will confirm the opportunities to organise support to the most complex people more effectively to improve outcomes and efficiency
- We will work with Home Improvement Agency leads and the Council's lead OT on opportunities to increase the impact of Disabled Facilities Grants. This work has commenced and has already highlighted the opportunities to consider DFG more widely as one of a range of options alongside deployment of supported or extra care housing; impact of work to improve housing conditions; options to use equipment rather than adaptation; retaining DFG adapted stock after the resident moves on; bringing together DFG and other funding to increase value; impact of handyperson services; role of "pathway flats" as an alternative to people being admitted to care homes or delayed in hospital pending works

**Governance**

This plan has been developed using a system wide BCF Steering Group comprising operational and clinical leads and commissioners together with the voluntary and community sector: Oxford University Hospital NHS FT, Oxford Health NHS FT (Community and Mental Health); Oxford City Council (Homelessness and Home Improvement Agency); West Oxfordshire, South & Vale and Cherwell District Councils (Home Improvement Agency); Oxfordshire County Council (Public Health, Adult Social Care); OCC/ICB integrated commissioning team; Oxfordshire Association of Care Providers; Age UK; Healthwatch (observers). This group reports to

- Oxfordshire Place Based Partnership Board (for strategic approach, narrative)
- Oxfordshire Urgent and Emergency Care Board (demand and capacity and metrics)


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- Oxfordshire Joint Commissioning Executive (sign off of plan and money for Council and ICB approval) and oversight of performance on behalf of the HWB

The responsibility for the delivery of this plan similarly will be governed by these bodies with Joint Commissioning Executive retaining the responsibility to report to HWB.

**Alignment with System UEC planning**

The plan has been developed alongside the ICB led development of the Urgent and Emergency Care plan and overseen by CFO and COO from all partner organizations. The UEC funding allocations have been deployed with reference to the deployment of BCF. The NEL and discharge metrics and the demand and capacity plans were approved by the Urgent and Emergency Care Board

**Bath, North-East Somerset, Swindon and Wiltshire ICB**

Agreement has been reached with BaNES, Swindon and Wiltshire to continue to invest as set out in the Plan to support flow out of Great Western Hospital. Data on Oxfordshire flow into that system will be maintained and reviewed with the local ICB on a regular basis in 2025/26.

## Section 2: National Condition 2: Implementing the objectives of the BCF

Please set out how your plan will implement the objectives of the BCF: to support the shift from sickness and prevention; and to support people living independently and the shift from hospital to home. This should include:

- A joint system approach for meeting BCF objectives which reflects local learning and national best practice and delivers value for money
- Goals for performance against the three national metrics which align with NHS operational plans and local authority social care plans, including intermediate care demand and capacity plans
- Demonstrating a "home first" approach that seeks to help people remain independent for longer and reduce time spent in hospital and in long-term residential or nursing home care
- Following the consolidation of the Discharge Fund, explain why any changes to shift planned expenditure away from discharge and step down care to admissions avoidance or other services are expected to enhance UEC flow and improve outcomes.


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**Joint system plan reflecting local learning and national practice**

The Oxfordshire BCF Plan for 2025/26 signals a shift from "clearing the backdoor of the hospital" to preventing admissions, and then in turn to community-based support that enables people to live independently. The plan is owned by the Place-Based Partnership and Urgent and Emergency Care Board and seeks to build on our exemplar practice Home First approach to develop those models of preventative interventions and care that will reduce activity and cost pressure and support a shift of funding into more preventative services.

The Oxfordshire system is directly aligning BCF spend with UEC funding and makes the case that a reduction in NEL bed days can and should fund some of the services involved in reduction of NEL. The BCF plan for 2025/26 will evaluate wider investment that is aligned to BCF to identify impact and value at the system level not just within the acute trust, e.g.to streamline and focus the range of community interventions that support hospital avoidance, or the review of support around homelessness mentioned above. It is our intention to identify the best use of the "Oxfordshire pound" to reduce our reliance on acute bed-based services and interventions: we have reduced reliance on beds in Pathway 2 discharges and will be commissioning a new model from July 2025; we have eliminated the annual purchase of additional "winter beds" in care homes; we now need to make the case for further shift from Pathway 2 to Pathway 1 in terms of impact, value and public acceptability, and construct the equivalent admission avoidance pathways that reduce the need for admission to acute beds.

Beyond beds Oxfordshire already invests significant funds in community capacity both within and outside of the BCF. There is evidence that this impacts on spend and intervention (activity-based interventions that reduce GP appointments; community capacity that reduces the need for care packages; assertive community models that reduce attendance at hospital) but this evidence needs to be further developed to give confidence that disinvestment in acute and urgent response is possible given a more resilient and independent population.

**National metrics**

- **NEL admissions.** We have modelled the NEL demand on General Medicine and Geratology to seek to achieve zero growth on 2024/25 levels. This seeks to mitigate the increase in demand of 6.02% which would otherwise happen based on year on year performance (leading to outliers in acute beds) and associated costs from an additional 6200 NEL bed days. The currency for this exercise has been NEL bed days which currently average 5.3 days per admission. To maintain 2024/25 levels, we will need to see an increased level of diversion of 23-30 patients per week. The BCF schemes will impact on people above and below 65 and so we will map locally the impact in both groups. The biggest growth in NEL in Oxfordshire is in people aged 50-64, especially in more deprived areas.
- **Discharge ready delay days**. In broad terms Oxfordshire has seen a fall in 2024/25 from 6.7 days average length of delay to 5.3 days. The numbers of people discharged


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each day has increased to >16 from +/- 12.5. Oxfordshire has seen a consistent reduction in days lost to discharge delay in all pathways in 2024 from the co-ordination and leadership of the TOC team allied to redesigned Home First and P2 reablement pathways. In 2025/26 we will aim to reduce the average length of delay days to 5. We do not anticipate significant changes to the percentage of people discharged on discharge ready day where this data is still subject to testing in UEC datasets and where predominantly the population in this instance is people on Pathway 0

    - The opportunities for further reductions in P1 and P2 may be limited at this stage: the median LoS in P1 is 3 days. There is capacity in all discharge pathways and the longer delays seem to be driven by process issues, especially in more complex cases. We will further develop capacity and capability (eg through trusted assessment) to review and manage the increasingly high level of Home First discharges especially when packages of live-in and overnight care are supporting the discharge. 30-day readmission rates remain at around 17-20% with the vast majority of readmissions taking place within 2WW. A review of December 2WW readmissions (41 cases) is under way to understand the risks and opportunities. The system view is that the focus for Oxfordshire needs to shift to front door rather than discharge to maintain flow

- **Permanent admissions to care homes**. In 2025/26 Oxfordshire will maintain the reducing trajectory in permanent adult social care funded admissions to care homes. We have reduced admissions against 2324 performance but not been able to hit the planned target in spite of embedding of strengths-based assessment and care planning and extensive use of community resources and access to housing alternatives. Local analysis confirms that 35-38% of all new LA "placements" are actually self-funders who have depleted their capital and now qualify for LA support. This suggests that the decision to enter a care home happened too early and was outside of the Council's control. We are developing a longer-term approach to advising and supporting self-funders to consider alternatives to residential care. This approach should have renewed impact from 2026/27

**Home First plans: see above-national metrics**

**Consolidation of ADF**

In 2024/25 Oxfordshire was given permission to divert money towards admission avoidance as the impact on Discharge was already being achieved without further investment. ADF was invested in developing a community single point of access, expansion of hospital at home and development of community-based teams that support admission avoidance and managing complex discharges home. Those schemes are initiated and will be further developed in 2025/26 and reflect the ongoing shift from discharge to prevention. In the end the D2A and reablement spend in 2024/25 far


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outstripped budget and these amounts have been increased in 2025/26, but largely from the reduction in spend in P2 beds from a reprocured more focussed service that will commence in July 25 after procurement. So, we have sustained and increased the investment in admission avoidance and diverted discharge spend from bed- to home-based services.

Please describe how figures for intermediate care (and other short-term care) capacity and demand for 2025-26 have been derived, including:

- how 2024-25 capacity and demand actuals have been taken into account in setting 2025-26 figures (if there was a capacity shortfall in 2024-25 what mitigations are in place to address that shortfall in 2025-26)
- how capacity plans take into account therapy capacity for rehabilitation and reablement interventions

**Capacity and demand development**

In 2024/25 Oxfordshire has not experienced any shortfall in capacity for reablement and short-term care either in terms of discharge or community response to avoid admission. The Live Well at Home framework has >100 providers and up to 30 of these have been trained and supported to deliver home first D2A. Access to the LWAH reablement and homecare referrals was expanded in August 2024 when existing providers could not keep up with demand and there is now continuous flow 7 days a week from acute hospital and step-down beds. The model of care includes 72hour assessment discharges, reablement and short-term care including live in and waking night support to get people home.

The median length of stay in P1 is 3.1 days and the average length of stay is 5.1 days at December 2024. Where length of stay is longer that is not due to capacity shortfalls but to process delays, including equipment, family negotiation and training in delegated healthcare tasks. The mean rate of recovery for reablement remains high at 75% in spite of the increased complexity of the population being taken home. We have extended the capability of the reablement providers and now deploy a Trusted Assessor approach wherever possible to support decision-making post assessment at 72hours.

The primary capacity issue for Oxfordshire in terms of P1 is keeping pace with the flow that we can achieve through the market. The system approach to this is to recognise that the primary need is to shift intervention and capacity to community reablement and rehabilitation to support admission avoidance and independence. The number of community reablement pick-ups has increased from 58 in Dec 2023 to 113 in Jan 2025 and the trajectory continues to grow. This community capacity can be used at times of surge for redeployment into acute flow.


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**Intermediate care capacity**

Intermediate care clinical capacity in Oxfordshire is constrained and we will be running a project to explore options and opportunities to improve that in 2025/26 by in the first instance looking to divert people from P2 to P1 for rehabilitation at home rather than in a bed base. This should identify options to reprofile intermediate care from bed- to home-based services.

Oxfordshire has capacity in a range of services aligned to urgent community response including step up into assessment and rehabilitation beds, community response, community reablement. Demand for and capacity to address this is mapped in the system urgent care data which is monitored monthly. In essence the demand for more urgent response is flexed to demand. The key shortfall relates either to triage capacity to support conveyance avoidance or to the visiting services that avoid the need for ambulance dispatch or disposition away from conveyance. The BCF and aligned UEC funds are designed to address these gaps through the further development of our single point of access which will move to be the "TOC equivalent" of community services.


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## Section 3: Local priorities and duties

Local public bodies will also need to ensure that in developing and delivering their plans they comply with their wider legal duties. These include duties:

- to have due regard to promoting equality and reducing inequalities, in accordance with the Equality Act 2010 public sector equality duty.
- to engage or consult with people affected by the proposals. For ICBs, trusts and foundation trusts this includes their involvement duties under the NHS Act 2006.
- for ICBs, to have regard to the need to reduce inequalities in access to NHS services and the outcomes achieved by NHS services.
- for ICBs, to have regard to the duty to support and involve unpaid carers in line with the Health and Care Act 2022

Please provide a short narrative commentary on how you have fulfilled these duties

**Equality**. The Oxfordshire HWB BCF plan has been reviewed against an Equality Impact Assessment. All schemes are backed by EIA. The focus of schemes has been to reflect those populations most at risk of health inequalities (most deprived wards, people living with mental health, drug and alcohol and learning disability and/or autism) and homelessness, both in terms of their interaction with community prevention and hospital discharge services, and in relation to specialist pathways.

**Consult**. In 2024 Oxfordshire undertook a large-scale engagement with our population in respect of the move to Home First models of care in the face of concerns re the perceived potential risks to the individual and loss of bed bases. Schemes funded by the BCF have their own service specific engagement approaches which are being compiled for the final plan as submitted. We have not had the opportunity to engage widely on this plan but intend to develop a workshop approach to sharing the learning and future plans in 2025/26

**Reducing inequalities**. The BCF plan is designed to address key inequalities as set out above.

**Unpaid carers**. The BCF plan includes funding for schemes that support the delivery of the Oxfordshire Carers Strategy as set out above.


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