Oxfordshire Better Care Fund Plan 2021/22

Health & Wellbeing Board: Oxfordshire

Introduction

Bodies involved in preparing the plan (including NHS Trusts, social care provider representatives, VCS organisations, district councils)

How have you gone about involving these stakeholders?

The development of the BCF plan has been led by officers from the Oxfordshire CCG and Oxfordshire County Council integrated commissioning team and has been approved on behalf of the Health & Wellbeing Board by the Oxfordshire Joint Commissioning Executive.

The detail of the winter planning initiatives in the iBCF for 2021/22 has been developed by the Oxfordshire Urgent Care Delivery Group delegated from the AEDB. The Group is led by Oxford University Hospitals NHS FT and comprises Oxfordshire County Council and CCG, Oxford Health NHS FT, South Central Ambulance Service, Age UK Oxfordshire, Principle Medical Limited and so covers acute and community health, primary care, social care and the voluntary and community sector. Urgent Community Delivery Group has also reviewed this submission and provided comments prior to Joint Commissioning Executive sign off.

The Better Care Fund plan builds out from a range of existing system wide plans and initiatives that are detailed in the Executive Summary below and which have been developed through different levels of system working.

The target metrics in the plan have been reviewed by Urgent Care Delivery Group and recommended to the Joint Commissioning Executive and AEDB.

The Disabled Facilities Grant narrative builds on the discussions held between District Councils and Oxfordshire County Council's therapy lead and integrated housing occupational therapists.

The Plan will be reviewed and signed off by the Oxfordshire Health & Wellbeing Board at its meeting on 16 December 2021

Executive Summary: Oxfordshire's key priorities for 2021/22

This plan brings together a number of strategic and operational initiatives to deliver

- A reduction in the number of unnecessary conveyances and admissions to hospital
- A reduction in long length of stay in acute hospital settings
- An increase in the proportion of people discharged to their own home after an acute hospital stay
- A reduction in the rate of permanent admission to long-term residential care

- An increase in the number of people who are still in their home after a period of reablement

We will deliver these outcomes via the the following improved objectives which frame the initiatives in our Better Care Fund Plan:

- Prevention and enablement: supporting people in their own community to manage their own needs through information and advice, strengths-based approaches and innovation
- Avoidance: where people are at risk of increased ill-health and loss of independence, Home First approaches and services that will help them remain safely at home and avoid either unnecessary conveyance for assessment, or admission to hospital or escalation to long-term care
- Home First approaches to supporting discharge from acute hospital settings through an improved and extended intervention to support people get safely back home where their short and long terms needs can be assessed and personalised plans developed for recovery and/or care
- A comprehensive model of assessment, and rehabilitation and reablement where people need to go home from hospital via a step-down bed in community hospital or nursing home. We are reviewing this pathway during 2021/22 to increase the number of people able to go directly home from hospital
- Support for the provider market at times of great pressure around workforce and cost
- Surge planning for winter and other risks

The key initiatives that will deliver these objectives are

- Implementation of Home First to support preventative services in the community and discharge to assess approaches to help people home from hospital via Pathway 0 and 1 as set out in Hospital Discharge Policy
- Implementation of Ageing Well Urgent Community Response to deliver a 7-day 2 hour and 2 day response to people at risk of conveyance and/or admission to hospital in the community or from ED
- An Integrated Care Improvement Plan developed by the Urgent Care Delivery Group on behalf of AEDB to assure delivery of the national UEC agenda
- Development of a Community Services Strategy that addresses
    - Those health inequalities identified in the Director of Public Health's JSNA
    - Prevention-building on learning from the Oxfordshire covid response and the Adult Social Care *Oxfordshire Way* re strengths-based approaches to increase resilience amongst our residents and communities
    - Alignment of community health services to the NHS Long-Term Plan in relation especially in relation to Anticipatory Care Planning, use of digital and estates to support planned personalised care around the needs of the individual
    - a review of community step down beds to improve the flow out of acute hospital via Pathway 2 of the Hospital Discharge Policy for implementation of a new model in 2022/23

- Development of Joint Commissioning Priorities
    - An emotional, mental health and wellbeing strategy for children and younger people
    - An Early Help Strategy and integrated therapies app model for young people
    - A Learning Disability and Autism Plan focussed on prevention, quality and the Provider Market relationship and designed to deliver the national strategy
    - The Community Services Strategy (above)
    - Building back and on from the pandemic response to assure quality and to develop our provider market relationship
- Development of our s75 NHS Act 2006 pooled budget agreement to deliver our integrated commissioning approach in an expanded pool from April 22 and to commission for outcomes that reflect a life course and tiers of need approach to supporting our population. This agreement will incorporate the Better Care Fund pooled budget from April 2022 and will enable a refresh of the specific plans and alignments necessary to deliver further integration of prevention, assessment and care from 2022/23. The agreement will also map our place-based approach to integrated commissioning with the ICS, and support opportunities to manage demand across the ICS footprint when that is the most appropriate way forward.

Better Care Fund Metrics 2021/22

BCF metric 8.1. Taken together we believe that the range of *preventative* and *avoidance* measures set out at pages 7-9 below will increase our capacity to manage the risk of non-elective admissions to hospital. Further we anticipate that the roll out of Ageing Well Urgent Community Response from October 2021 will increase this resilience with the 2HH and 2DD response delivered 0800-2000 7 days a week. The 2019/20 baseline for NEL was artificially low owing to the impact of the pandemic response. There was a steep increase in Q1 2021/22, and these pressures have continued. In view of this we have set a target to reduce by 5% from the 2018/19 performance.

BCF metric 8.2. Oxfordshire AEDB manages progress towards the Oxford University Hospital metric of no more than 12% of open acute beds occupied by people with length of stay >21 days. This target represents a reduction from the March 21 baseline from 14%.

The BCF metric is not one that has been monitored before and the average length of stay approach needs to be understood in terms of its sensitivity to the measures that we have outlined here in terms of avoidance and supporting safe discharge. We also note that this planned reduction is on the face of it deeper than the acute trust metric and we do not have any information on how the 2 metrics relate to each other.

We therefore propose a reduction to the BCF metric baseline in the same proportion to the reduction that is required for the acute measure (i.e by 2/14 or 14% by end of Q4 2021/22. We will develop monitoring approaches that support our understanding of progress, barriers and opportunities in delivery of this metric.

BCF metric 8.3. The current proportion of people discharged home is 91% with 7.2% going into pathway 2 step down beds; however, if we break that down into people aged over 65 the proportion is 88% going home and 10% going into pathway 2. The increased reablement capacity funded as part of our surge plan will positively impact these numbers, together with the impact of avoidance (well over 95% of all patients in step down beds were non-elective admissions to acute settings). However, we retain a large bed base and so anticipate that we will not achieve the 95% national expectation in 2021/22. **We therefore plan to achieve 93% in 2021/22**.

BCF metric 8.4. Residential admissions to nursing homes are driven both from the community and as part of hospital discharge. We are continuing to work with housing provider partners to develop Extra Care Housing and have designed a new care approach into those flats as part of Live Well at Home. We will continue to drive our Home First approach for discharge and exploring all alternatives to permanent admission (eg in our community equipment and assistive technology schemes). We are therefore looking to fund no more than 11 permanent admissions to care homes per week. **We plan for 429 admissions in 2021/22 per 100k of population over the age of 65**.

BCF metric 8.5. The impact of reablement on longer-term care needs is set out above and with the Home First and strengths-based prevention work we anticipate that this will mean a **recovery in the numbers of people still at home 90 days after reablement episode to 77%**.

Key changes since 2019/20 Plan

Oxfordshire used the impact of the covid pandemic to develop a range of responses that improved prevention, avoidance, integrated infrastructure and system flow. These were developed directly out of our experience of system escalation with senior strategic leadership, and of mobilising a wider range of community and other services to manage the needs of our population. These initiatives have been implemented as business as usual and form a large part of our Better Care Plan:

- Oxfordshire has implemented an integrated commissioning team across Health, Social Care (children and adults) and Public Health. This went live on March 1 2021
- Oxfordshire has developed a new Home First MDT to support discharge home from hospital and management of people at risk in the community. The new team went live on 1 October 2021
- The Home First MDT is working in partnership with new strategic providers of reablement and domiciliary care commissioned by the County Council and CCG under Live Well at Home contracts. Live Well at Home also went live on 1 October 2021
- The Live Well at Home model also includes a new approach to supporting people in Extra Care Housing with a zonal domiciliary care model where contracts will expand over time to pick up new schemes that open in the geography

- Oxfordshire has begun delivery of the Ageing Well Urgent Community Response from 1 October 2021. This programme is funded externally to BCF but we are working to align the interface between Home First and Ageing Well
- Oxfordshire has commissioned new integrated Dementia and Carers services from April 2021. Delivered by partnerships in the voluntary and community sector these services extend advice, information and personalised support to our population
- Adult Social Care has introduced a Transformation Programme called *The Oxfordshire Way* in 2021 to develop strengths-based approaches to assessing and planning support for people in the community within adult social care teams. This template is being used to develop the prevention approach within the Community Services Strategy
- Oxfordshire is refreshing our relationships with the independent provider market to reflect the challenges that they have experienced during the pandemic. We are seeking to move to a more strategic relationship with key providers (evidenced in our new Live Well at Home contracts) and to support them through an improved Trusted Assessor and other initiatives, such as support to Care Homes at an Enhanced level beyond the national Ageing Well Direct Enhanced Service

Governance

The Oxfordshire Health and Well-Being Board has overall responsibility for the Better Care Fund Plan and will review the plan at its meeting in December 2021. The Board is familiar with several elements of the Plan and has endorsed the new Community Services Strategy.

Commissioning oversight of the Plan and pooled budgets in the s75 NHS Act 2006 is delegated to the Joint Commissioning Executive. The Deputy Director, Commissioning is the Pooled Budget Manager for the s75 (including the Better Care Fund) and reports to the Joint Commissioning Executive.

The Home First model has been developed and its implementation is assured on behalf of the system by the Home First Strategic Group. This group reports into both AEDB (for operational performance and impact) and to the Joint Commissioning Executive (for assurance for spend).

The specific surge/winter planning elements to the plan funded from the iBCF by the Joint Commissioning Executive are delegated to the Director of Adult Services, Oxfordshire County Council and the Chief Nurse, Oxford University Hospitals NHS FT. These have been developed by the Urgent Care Delivery Group reporting to AEDB.

Plans in respect of the Disabled Facilities Grant are developed by the County Housing Forum, a joint meeting of District Council leads and the Lead Occupational Therapist Oxfordshire County Council and the integrated housing OTs and lead commissioners.

In 2021/22 Oxfordshire has developed and initiated a range of projects and programmes at the same time as we are developing new structures at Place and ICS

level in line with the developing NHS ambition. During the remainder of this year these structures will be formed and we will identify the best place to locate the development of our future Better Care Fund plans.

Overall approach to integration

In 2021-22 health, social care and public health commissioning has been brought together in one integrated joint commissioning team hosted by the County Council. Headed by a new Deputy Director post reporting to Directors of Adults, Children and Public Health in the County Council and the Deputy CEO for the CCG, there are 17 joint funded posts commissioning support and outcomes across a life stage (start, live, age well) and tiers of need (prevent, enable, support and protect) approach. This team deploys the budgets in Oxfordshire's s75 NHS Act 2006 pooled budget (value £300m) including the Better Care Fund. The pooled budget arrangements are being developed in a new s75 to be effective from April 22 which will increase the impact of these pooled funds by improved alignments/elimination of silos derived from the preventative, enabling and outcomes-focussed ambition in the integrated model. Commissioning of services deployed within the Better Care Fund is now fully integrated across health and social care.

The overall approach set out in this plan covers the following domains

- Prevention and enablement: supporting people in their own community to manage their own needs through information and advice, strengths-based approaches and innovation
- Avoidance: where people are at risk of increased ill-health and loss of independence, Home First approaches and services that will help them remain safely at home and avoid either unnecessary conveyance for assessment, or admission to hospital or escalation to long-term care
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- Surge planning for winter and other risks

These schemes are delivered across the minimum CCG contribution, iBCF and in externally funded schemes as set out below. The plan covers both existing and 2021/22 new schemes.

Prevention
Housing and adaptations: see below.

In 2021 Adult Social Care has introduced a Transformation Programme called *The Oxfordshire Way* to develop strengths-based approaches to assessing and planning support for people in the community within adult social care teams. Working with Age UK Oxfordshire and Active Oxfordshire this has sought to identify different, more enabling and personalised ways of supporting people in their own homes, both increasing independence and wellbeing and reducing the need for formal care.

This initiative currently is resourced outside of the BCF but much of the resources available to it are funded from the BCF: Live Well Oxfordshire, an information, advice and on-line self-help resource for people and agencies; Community Catalysts, a series of micro-providers who can provide targeted and personalised support within someone's own community; and a range of innovation grants to local community groups to support prevention and resilience. These services also work closely with primary care social prescribing and District Council advice and information hubs. This template is being used to develop the prevention approach within the Community Services Strategy which seeks to build on the mobilised community response which we mobilised to support people during the pandemic lockdown. Oxfordshire also invests BCF funding in our joint health and social care equipment budget to support people in their own home and in telecare and assistive technology to develop new ways of supporting people to live independently and without restriction.

In April 2021 we launched an integrated health and social care new service funded by BCF for Carers which brings together advice, information, practical support and a grants programme administered by the voluntary sector partnership that is delivering this.

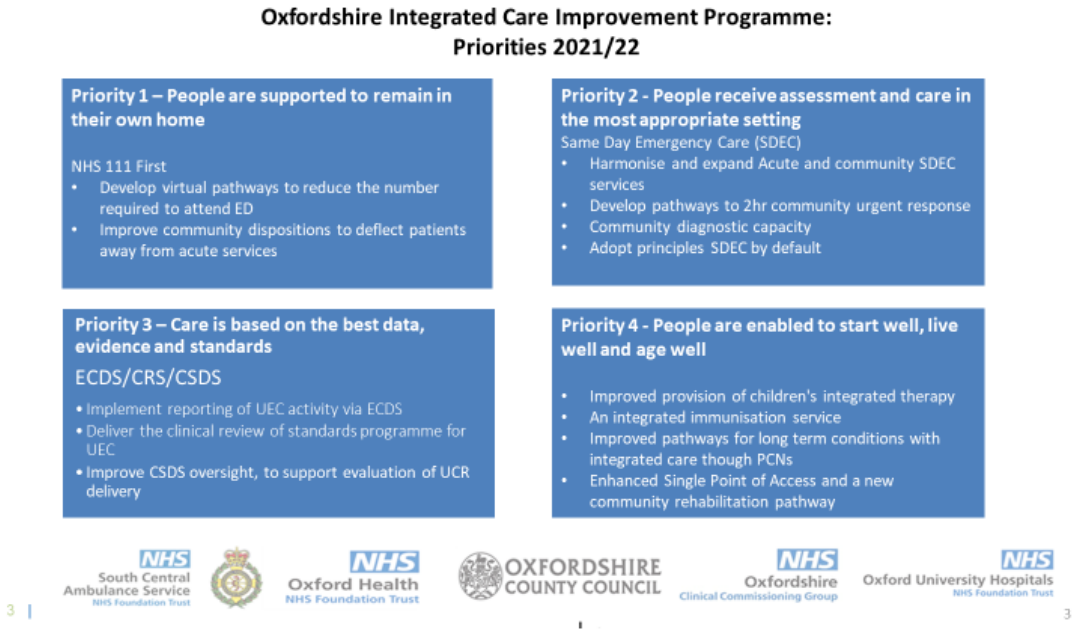
In April 2021 we also launched an integrated advice, information and support service Dementia Oxfordshire again delivered by a voluntary sector partnership. The service works closely with primary care

Finally, the prevention programme includes our local falls service delivered by Oxford Health which works closely with Generation Games (Age UK Oxfordshire | Generation Games), another Age UK initiative that offers strength and balance classes (now on-line as well as in person) to help people reduce the risk of falls. Parts of Oxfordshire are significant outliers in terms of admissions to hospital due to falls and this will form one of the key work streams in developing Community Services Strategy.

Taken together with initiatives under Home First (next section) our preventative approach underpins our approach to BCF metrics 8.3, 8.4 and 8.5.

Avoidance
In this domain the BCF plan is aligned to two key system plans and together these are working to reduce the number of non-elective admissions (BCF metric 8.1):

The Oxfordshire Integrated Care Improvement Programme



This is led by Oxford University Hospitals NHS FT via the Urgent Care Delivery Group reporting to AEDB. It is designed to implement the national UEC standards in Oxfordshire. It is built around Home First and preventative approaches to create alternatives to conveyance and/or admission to hospital. It includes-in Priority 4-a pilot to develop a PCN based approach to anticipatory care planning which integrate primary, community and acute health physicians with support from social care and the voluntary sector to avoid unnecessary exacerbations.

The second key system initiative is *Ageing Well Urgent Community Response.* As part of the BOB ICS accelerator site Oxford Health NHS FT is leading on the implementation of an extended single point of access and a 2-hour and 2-day response to people at home or in ED. This provides assessment and intervention from 0800-2000 7 days a week from October 2021. We are working on the interface between this service and Home First and a BCF funded social worker from the hospital team will work into the new service through to March 22 to support this and implementation.

The Urgent Care Delivery Group has developed a number of related schemes for 2021/22. that will support hospital avoidance and which are funded from the iBCF. The plan is that if these are evaluated as being successful that we will move to make them business as usual and identify a funding stream to support that:

- Extended consultant support and advice to 0200 am to paramedics and other clinicians to support decisions on conveyance
- Extended support into front door of ED and acute ambulatory settings: an expansion of the front door therapy team to work with people in assessment and link with Ageing Well Urgent Community Response and Home First teams to create safe plans to transfer home; and an expansion of medicines capability to support timely turnaround and discharge

- Expansion of the Emergency Department Psychology Service into minor injuries units
- Development of a community-based paediatric response linked to acute clinicians to enable children and their parents to be safely supported at home

These initiatives will work with existing health and social care front door assessment and intervention services delivered under BCF: the Oxford Health Emergency Multidisciplinary and Rapid Assessment and Care Units at sites around the county which support patients and with medically led assessment and care and step up bed provision if indicated for short stay and turnaround in community hospital sites; and the County Council Front door and emergency duty teams and allied urgent domiciliary care response delivered by the new Live Well at Home strategic reablement and domiciliary care providers. They also work with the local extended support to care homes which goes beyond the national Ageing Well Urgent Community Response DES to provide additional support to MDT around mental health, speech and language therapy, nutrition and dietetics and in supporting homes with training and other quality assurance processes. This is delivered in partnership by Primary Care Networks and Oxford Health's Care Home Support Service.

BCF metric 8.1. Taken together we believe that the range of *preventative* and *avoidance* measures set out above will increase our capacity to manage the risk of non-elective admissions to hospital. Further we anticipate that the roll out of Ageing Well Urgent Community Response from October 2021 will increase this resilience with the 2HH and 2DD response delivered 0800-2000 7 days a week. The 2019/20 baseline for NEL was artificially low owing to the impact of the pandemic response. There was a steep increase in Q1 2021/22, and these pressures have continued. In view of this we have set a target to reduce by 5% from the 2018/19 performance

Supporting Discharge: see next section

Support for the provider market

We are seeking to develop a more strategic relationship with our provider market, both from the integrated commissioning team and in operational settings. This will reflect learning from the pandemic response and recognise our common challenges in relation to workforce, increased acuity of patients and the need to develop responses that reflect our JSNA and equality impact assessments.

Within the BCF we are funding

- The new Live Well at Home reablement and domiciliary care contract with strategic providers to develop a more integrated approach with assessment and review and provide a funding approach that supports the employment of staff on full-time rather than zero hours contracts. These staff will also be supported and developed by working alongside the Home First MDT as part of "one team"
- Workforce support and initiatives on recruitment and retention, including the Proud to Care website jointly with the Oxfordshire Association of Care Providers Home - Proud To Care (proudtocareoxfordshire.org.uk)
- Fee uplifts and provision for new business to reflect increasing demand

- The locally enhanced care home support offer set out above which assists residents but also the home and its staff in developing quality approaches
- A revised and extended Trusted Assessor programme to improve the conversation and understanding between hospital discharge teams and providers. This is being developed with and will be delivered by Oxfordshire Association of Care Providers.

Surge planning

For winter 2021/22 we have set aside £1.3m for additional capacity. The plan is to use this to supplement Hospital Discharge Funding.

At this stage we plan to expand our reablement capacity from the planned 75 pick ups per week by 50-75% from Dec 21 to Mar 22 by retaining the outgoing service alongside the new Live Well at Home strategic providers.

We will also use this fund to support additional interim step-down bed capacity where indicated.

Supporting Discharge (national condition four)

Oxfordshire's discharge approach is funded through the BCF. It comprises support to people going home and people going home via step down beds. Overall Oxfordshire's approach is *Home First.*

Oxfordshire has developed a new integrated Home First MDT to support discharge home from hospital and management of people at risk in the community. The new team has been funded by the iBCF and the uplift to the minimum CCG contribution. Hosted by the County Council the team includes physiotherapists from Oxford Health and aligned staff from Age UK Oxfordshire. The Age UK team review people on the reablement list and identify and support those who can be helped home without or in advance of formal support. This service is funded from iBCF. The new team went live on 1 October 2021.

The Home First MDT is working in partnership with new strategic providers of reablement and domiciliary care commissioned by the County Council and CCG

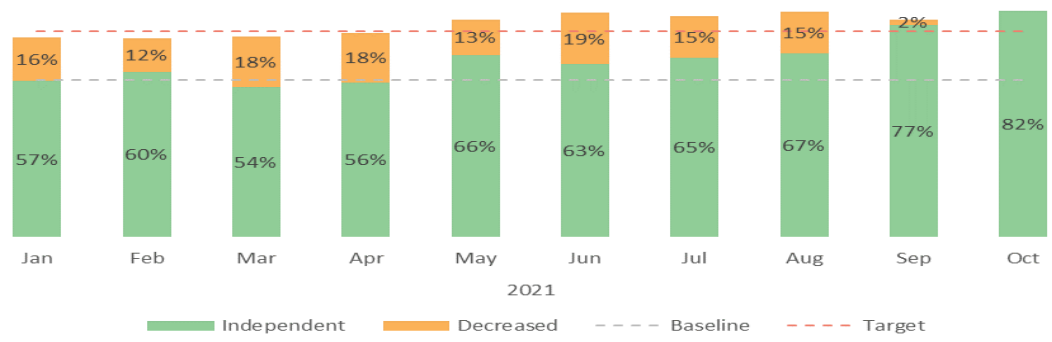
under *Live Well at Home* contracts. The reablement capacity will be deployed by the MDT and is funded in part by BCF. The funding model has been set to support the employment of staff on salaries rather than zero hours contracts. Live Well at Home also went live on 1 October 2021. The implementation of this approach is overseen by a system wide Home First Strategic Group.

Our surge plan for winter is to expand the reablement offer from 75 pick ups per week by 50-75% from December to March 22. This is funded (as above from the BCF minimum CCG contribution). This is a key element in increasing pick and reducing length of stay.

Oxfordshire has a comprehensive Pathway 2 comprising (currently) 130 community hospital beds delivered by Oxford Health NHS FT and 97 step-down beds in nursing homes supported by the Hub team within Oxford University Hospitals NHS FT Discharge Liaison service. The Hub allocates patients to Pathway 2 and provides nursing and therapy support to the nursing home beds to support discharge to assess and reablement approaches. In some homes the therapy is provided by Oxford Health community therapy. All of this activity is funded by the BCF, with additional funding from the CCG to support medical cover to community hospitals and nursing homes. The BCF also funds the social work input to both pathway 2 and pathway 3.

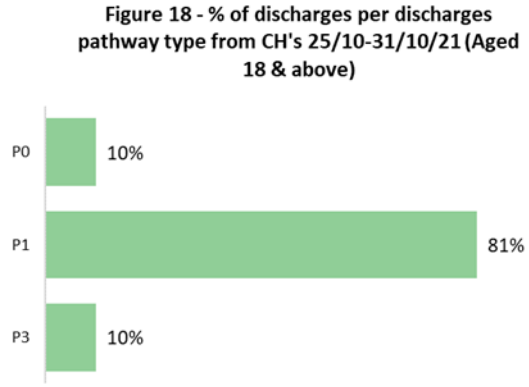
Although the Home First approach has been formalised in new contracts and services from 1 October, the model has been developed and implemented over time and we can see the impact of reablement in returning people to independence or reduced packages of care:

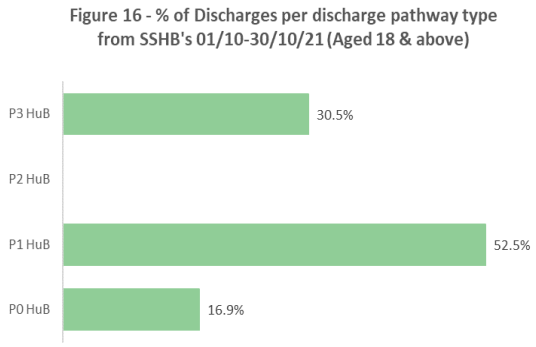
Figure 10 - % reablement patients discharged inde[pendent or decreased POC (Reablement Start Date)



The introduction of the Hospital Discharge Policy has highlighted the proportion of people discharged via Pathway 2 rather than home and our new Home First approach is designed to address this. We are also within the Community Services Strategy reviewing the inputs and outcomes within our step-down beds to identify those people who can be diverted from step down beds and/or can go home from those beds earlier in their stay. This will help us understand the scope to reduce or repurpose beds through greater throughput and more targeted and personalised interventions.

Currently over 90% of people supported in community hospital settings are discharged home with or without support; and 69% from short stay hub beds in nursing homes.





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We therefore propose a reduction to the BCF metric baseline in the same proportion to the reduction that is required for the acute measure (i.e by 2/14 or 14% by end of Q4 2021/22. We will develop monitoring approaches that support our understanding of progress, barriers and opportunities in delivery of this metric.

	March 21	June 21	Sep 21	Dec 21	Mar 22
Proportion of patients resident in acute beds 14 days or more	8.6%	8.8%	8.4%	**8.0%**	**7.4%**
Proportion of patients resident in acute beds 21 days or more	3.9%	4.2%	3.8%	**3.7%**	**3.4%**

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95% national expectation in 2021/22. **We therefore plan to achieve 93% in 2021/22**.

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Disabled Facilities Grant (DFG) and wider services

Oxfordshire County Council has integrated functions with Cherwell District Council and the Director of Adult Services is also the Director of Housing. This creates perspectives that support a better understanding of how housing and social care can be aligned to deliver best value and better outcomes for our population. In addition, the integrated commissioning structure now means that health can be built into this planning. The current Interim Director of Housing is reviewing our DFG and Home Improvement Agency services to develop recommendations for 2022/23.

Spend of DFG and the implementation of Home Improvement Agency is overseen by the County Housing Group chaired by the Lead for Occupational Therapy at the County Council. 4 of the 5 district councils use part of their allocation to pay for dedicated housing OTs in the County working both with children and with adults. These OTs work alongside Home Improvement teams and housing officers to identify the best way forward in each case: whether there is an equipment alternative; whether the DFG represents the best use of resources and/or whether alternative accommodation may be more viable and in the longer-term interest.

There is scope to develop this work into a view of the inter-relation between care costs (health and social care), housing (tenancy) costs, equipment and adaptation costs to determine whether there is (for instance) the opportunity to create more bespoke and personalised packages. These may identify opportunities for efficiency as well as meet user need. These ideas will the considered as part of the current review.

Equality and health inequalities

We have completed an Equality and Climate Impact Assessment to support the Better Care Fund Plan and this will be reviewed in Q4 2021/22 especially in relation

to an improved understanding of the impact of our performance on BCF metrics in relation to protected characteristics. .

The Oxfordshire JSNA has identified both geographical populations (in parts of Banbury and Oxford) and areas of need where Oxfordshire does worse than baseline, especially in relation to younger people and older people, where prevalence of depression, loneliness and falls are above average and the dementia diagnosis rate is below.

These findings have informed the Better Care Fund Plan for 2021/22 with a range of specific schemes that are detailed above and in the template but which include

- A new community paediatric care pathway funded through iBCF that is designed to avoid unnecessary attendance and admission for vulnerable young people
- Increased mental health capacity in minor injury units
- New dementia and carer support services, and a focus on the falls pathway
- The focus in the deployment of the DFG and Housing Improvement on supporting people with behaviours that challenge with emotionally sustainable building design which supports sensory needs
- A range of preventative services delivered in partnership with community services that we are seeking to target in areas of greatest need as defined by the JSNA