Local Government Association

NHS England

Oxfordshire Better Care Fund submission – January 2015

Better Care Fund planning template – Part 1

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

Both parts of the plans are to be submitted as attachments to bettercarefund@dh.gsi.gov.uk as well as to the relevant NHS England Area Team and Local Government representative.

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 (lead submission)**
	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:	**8 January 2015**
Date submitted:	**9 January 2015**
Minimum required value of BCF 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	

Signed on behalf of the Clinical Commissioning Group	**NHS Swindon Clinical Commissioning Group**
By	
Position	
Date	

Signed on behalf of the Clinical Commissioning Group	**NHS Aylesbury Vale Clinical Commissioning Group**
By	
Position	
Date	

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

c) 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.**
Oxfordshire's Joint Health and Well-being Strategy 2012 – 2016 (Revised June 2014)	3 year vision and joint strategy for improving the health of Oxfordshire residents as defined by the Health and Well-being Board (Oxfordshire County

	Council).
NHS England: Emergency Admissions for Ambulatory Care Sensitive Conditions (ACSC) – Characteristics and trends at a National level (March 2014)	NHS England sponsored research that identifies 5 long-term condition ACSCs and 7 acute condition ACSCs, most likely to result in a non-elective admission (NHS England).
Older People' Joint Commissioning Strategy 2012-2016	A commissioning strategy focused on delivering improvements for older people in Oxfordshire underpinned by an outcomes-based commissioning approach (Oxfordshire Clinical Commissioning Group).
Oxfordshire Clinical Commissioning Group (OCCG) Strategy 2014/15-2018/19.	This document sets out the strategic intent of Oxfordshire CCG to reform the health and social care system in Oxfordshire, through improving system leadership and by developing a whole-systems, partnership approach to creating financially viable, sustainable and high quality provision that will meet the changing needs of Oxfordshire's population over the next 5 years and beyond (Oxfordshire Clinical Commissioning Group).
Report on the Oxfordshire Care Summary.	
The Oxfordshire Delayed Transfers of Care Plan (December 2014).	Plan to address the main reasons for delayed transfers of care in the acute sector (Oxfordshire Clinical Commissioning Group).
Oxfordshire patient choice, equity and fair access policy (August 2014).	Joint policy designed to support patients and their families regarding choice of ongoing care (Oxford Health NHS Foundation Trust).
Most capable provider assessment for older people’s services (August 2014).	Joint venture between OUH and OHFT in response to OCCGs outcomes-based commissioning intentions for older people (Oxford University Hospitals NHS Trust and Oxford Health NHS Foundation Trust).

Oxfordshire Better Care Fund

January 2015
Planning Template – Part 1

1) Executive Summary

Oxfordshire's Better Care Fund (BCF) Plan sets out our vision and strategy for transforming the system to optimise patients' receiving the right care, in the right place and at the right time, first time.

Our plan is focused on addressing our performance in respect of failing to meet the 95% A&E target, and on our enduring track record of unacceptable delays in hospital transfer. As a whole-system we have signed up to a 2% reduction in non-elective care and have chosen to invest circa £37.5m in schemes that will improve our performance in this regard. The principles underpinning our schemes are designed to:

- Integrate services across organisational/sector boundaries,
- Enhance individual self-care management,
- Provide rapid access to community/primary care based urgent care 24/7,
- Provide a greater range of services closer to home,
- Increase the number of patients who can be managed on ambulatory care pathways, and
- Reduce delayed transfers of care in the acute sector.

We have committed to protecting adult social care with an investment of £8m, and we will be allocating £1.35m to support the implementation of the Care Act 2014.

We have reinforced the governance supporting our plans through the Health and Wellbeing Board, by implementing robust leadership of the system through our System Leadership Group.

Our BCF plan is aligned to our strategic commissioning plans across the system including the health and wellbeing strategy, and Oxfordshire Clinical Commissioning Group's (OCCGs) 5 year strategic plan. Our plans will be refreshed annually to incorporate local learning and experience, and in line with national guidance in respect of the 5 year Forward View (NHS England,October 2014).

By 2019 delivering our vision for Oxfordshire's citizens will mean achieving our priority targets including:

- Reducing the proportion of people who are inappropriately admitted to hospital when other sources of care could have been available;
- Reducing the proportion who spend longer in hospital than they need to;
- Reducing the proportion of people admitted to residential and care homes across Oxfordshire.

2) Vision for Health and Care Services

a) Drawing on your JSNA, JHWS and patient and service user feedback, please describe the vision for health and social care services for this community for 2019/20

Our Vision in Oxfordshire

To support and promote strong communities so that people live their lives as successfully, independently and safely as possible. We believe that people themselves, regardless of age or ability, are best placed to determine what help they need. The role of health and social care commissioners and providers is to ensure that everyone who needs it has access to the right care, in the right place, at the right time, first time.

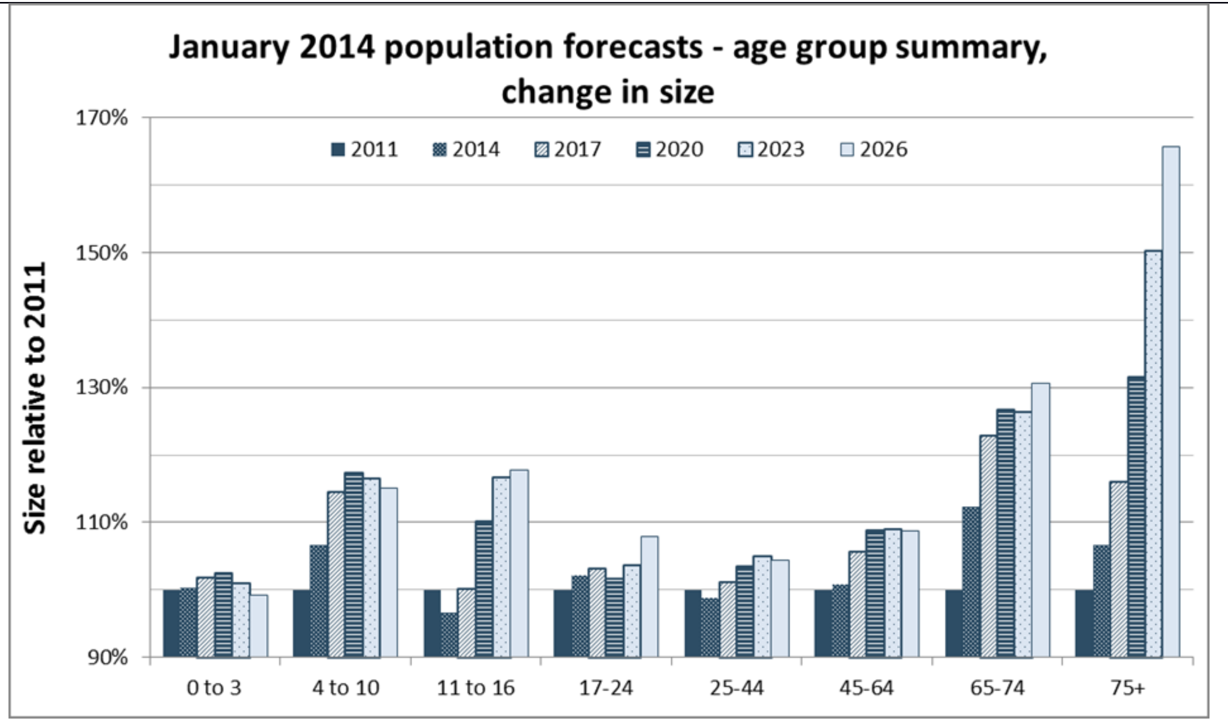
The Oxfordshire Context

The Oxfordshire Health and Social Care partnership landscape comprises commissioners: Oxfordshire County Council (OCC), 5 district authorities and Oxfordshire CCG; and providers: Oxford University Hospital NHS Trust (OUH), Oxford Health Foundation NHS Trust (OHFT) (provider of community and mental health NHS services) and 82 GP practices. In addition the health and social care system are reliant on the independent sector for domiciliary home care and residential care and nursing home provision.

Oxfordshire has a population of approximately 655,000. At the time of the 2011 Census, Oxfordshire's population was forecast to grow by 93,000 (14%) over 15 years reaching 748,000 by 2026. The proportion of the population above 65 years is forecast to increase from 16% in 2011 to over 20% by 2026, whilst the proportion of working age is forecast to fall. Forecast increases are most dramatic in the oldest groups: 66% growth in the 75+ group (from 50,000 in 2011 to 82,000 by 2026) and 69% growth for the 85+ group (up from 15,000 in 2011 to 25,000 in 2026). The rate of growth among these age groups is predicted to be highest in rural areas of the county, with numbers remaining relatively constant in Oxford City[1].

This makes the delivery of the BCF plan a key priority in ensuring a sustainable health and social care system for the future.

1 2014 Housing led Population Forecasts, Research and Intelligence Team.



As we face up to the scale of the challenge for improving care in Oxfordshire, we are committed to involving and consulting our population on the outcomes that matter to them, through the Older People's Joint Commissioning Strategy 2012 – 2016 which was widely consulted on in January 2012. The primary outcomes that we want all our older residents to be able to say are:

- I can take part in a range of activities and services that help me stay well and be part of a supportive community.
- I get the care and support I need in the most appropriate way and at the right time.
- 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.
- As a carer, I am supported in my caring role.
- If 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.
- I see health and social care services working well together.

The Oxfordshire Joint Strategic Needs Assessment[2] (JSNA) states that by 2016:

- 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;
- 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;
- everyone will be given the opportunity to voice their opinions and experiences

2 Oxfordshire's Joint Health and Well-being Strategy 20112-2016 (Revised June 2014).

to ensure that services meet their individual needs;
- the best possible services will be provided within the resources we have, giving excellent value for the public.

These principles have been aligned to the strategic objectives for the Oxfordshire health and social care system enshrined in the OCCG Strategy 2014/15-2018/19. The document sets out a 5 year commitment to ensuring that the health and social care system will:

- Be financially sustainable.
- Be delivering fully integrated care, close to home, for the frail elderly and people with multiple physical and/or mental health needs.
- 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.
- Routinely enable people to live well at home and to avoid admission to hospital when this is in their best interests.
- Be continuing to provide preventative care and to tackle health inequalities for patients and carers in both its urban and rural communities.
- 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.

Over the next two years we will deliver this, through the delivery of our joint BCF plan and through joint commissioning arrangements with NHS England. In order to deliver the ambitions of this plan, we will need to shift activity and resources into different parts of the system. By 2018/19 our goal is to reduce the amount of time spent avoidably in hospital through the provision of better integrated care in the community, by approximately 31%[3] and through increased investment in primary care.

Taking into account the joint plans and strategies for Oxfordshire described above, we have set ourselves 3 critical success factors which we expect the BCF plan to achieve:

- To reduce the proportion of people who are inappropriately admitted to hospital when other sources of care could have been available.
- To reduce the proportion of people who spend longer in hospital than they need to.
- To reduce the proportion of people admitted to residential care and nursing homes across Oxfordshire.

What changes will be made?
Our vision is to provide person-centred care, immediately available, at the point at

3 National composite measure (EA4) of: unplanned hospitalisation for ACS conditions and u'19s with asthma, diabetes and epilepsy; emergency admissions for acute conditions not normally requiring admission and children with lower respiratory tract infections.

which an individual needs care. This will mean all agencies and providers working collaboratively to deliver a new model pathway that transcends the traditional boundaries between primary, community, hospital and social care, working alongside voluntary and other independent sector agencies.

Our plans for transformation are underpinned by 6 design principles which provide a framework for assessing the primary constraints in the system, and for structuring our emerging urgent and emergency care strategy including the Better Care Fund:

1. Integration of services overcoming organisational and sector boundaries:
This approach reflects our belief that the provision of health and social care services should be built around patient/service user needs thus reducing complexity, duplication and hand-offs between services. Of paramount importance is the integration of primary care with community health and social care, and interface with acute emergency services. Integration of primary care with other services should be driven at a locality level, thus ensuring services are locally responsive and joined up.

At the heart of this change will be integrated neighbourhood teams directing the suite of primary care, and community health and social care services wrapped around GPs and their patients to forge common goals for improving the health, well-being and experiences of local people and communities.

We are currently engaging with the primary care community with a 'call for ideas' initiative to develop greater impetus around primary care as a solution to spiralling demand for acute services via non-elective admissions and delayed transfers of care. Primary care federations are under development across Oxfordshire, and it is through these collaborative networks that we will develop our primary care improvement strategy and our bid in respect of the Prime Minister's Challenge Fund

2. Enhancing self-care management:
We are committed to enabling those with disabilities and long term conditions, with the education and support they need to be as independent as possible. We believe that empowering people to have greater control of self-care management for conditions such as asthma, chronic obstructive pulmonary disease (COPD), heart failure and diabetes, reduces the likelihood of avoidable emergency admissions and premature dependency on long term care interventions. Primary care investment lies at the heart of this initiative.

In addition our BCF plan is already committed to investment in equipment and assistive technology which is crucial to supporting community resilience.

3. Rapid access to community/primary care based urgent care 24/7:
Improving the responsiveness and accessibility of community and primary care based urgent services are key to reducing avoidable demand for acute emergency care services. This also includes focused attention on timely and integrated solutions to support frail, older people who are at high risk of emergency admission. We plan to improve the interface between GPs and specialist gerontology and medical services, thus increasing the proportion of individuals who can be assessed in their own homes or community facilities, such as Emergency Multi-disciplinary Units (EMUs) as a better value alternative to acute emergency care, which is often

inappropriate to meet their needs. We also recognise the important role of primary care out of hours and during escalation, and believe that improvement in these areas has the potential to improve care quality and lead to a reduction in emergency care costs.

7 day operations including out of hours and at weekends is an essential element of this design principle, to ensure that care pathways no longer default back to acute based emergency care, when this avoidable.

4. Care closer to home:
We believe that care closer to home starts with enabling those who are the most vulnerable and at risk of an inappropriate emergency admission, being cared for in their place of residence wherever and whenever possible. In addition preventing unnecessary acute episodes of care requires a range of community intermediate care services (community inpatient facilities; community day hospital; hospital at home and domiciliary care) that are equally responsive to the needs of individuals requiring either step-up or step-down facilities; are joined up; and actively manage transitions including timely and accurate information, good communication between hospital and primary physicians; and a single point of co-ordination.

Our plans will ensure that people at the end of life have greater choice regarding where they will die, and we will support them to exercise this choice through wide implementation of advance care plans. Linked to this we will invest in proactive medical support to residential care and nursing homes to ensure that the health and well-being of residents is well managed so that the signs of illness and deterioration are identified at the earliest opportunity.

5. Ambulatory Emergency Care:
We recognise that many acute and medical conditions that result in high numbers of patients being admitted to hospital, can be successfully managed in an ambulatory care setting. Through clinical collaboration between GPs, emergency care medical consultants and the ambulance service, we are developing pathways for a range of ambulatory care sensitive conditions (ACSCs) that have the potential to improve patients reported outcomes for these conditions, and reduce avoidable demand for urgent and emergency care. In particular we are prioritising the 5 long-term ACSCs and 7 acute ACSCs identified by NHS England[4].

6. Reducing delayed transfers of care:
Delayed transfers of care (DToC) have been an enduring feature of the health and social care landscape in Oxfordshire since April 2011 when the Department of Health first started to publish the number of people delayed in inpatient care. At 27.2 per 100,000 population, Oxfordshire is almost 3 times the England average 9.7 per 100,000[5]. Delayed transfers of care reduce the flow and smooth transition of patients between all health and social care services. It leads to crowding in the emergency department, which in turn leads to delays in emergency medical assessment, which

4 NHS England: Emergency Admissions for Ambulatory Care Sensitive Conditions – Characteristics and Trends at a National Level (March 2014).
5 Department of Health: Delayed Transfers of Care population statistics average 2013/14.

in turn increases the likelihood of avoidable emergency care admissions. All Oxfordshire partners have recently collaborated on the development of a whole-system plan for tackling the issue, recognising that solving this problem will have a dramatic impact improving patient experience and on reducing the cost of emergency care.

In addition two cross-cutting strategies that embrace the design principles above have been agreed:

The Oxfordshire Joint Older People's Strategy (Outcomes-based Commissioning) 2012-2016:
This involves embedding an outcomes-based commissioning approach to older people's care, currently the subject of a most capable provider assessment of an alliance between OHFT and OUH being conducted by OCCG. The primary outcomes include defining and improving a care pathway for frail elderly people; expansion of EMU services in Oxford City and Banbury, and via 'virtual' means using telemedicine technology and hospital at home design principles to extend the reach of the current EMU service; and through improving the interface between reablement, supportive hospital discharge services (SHDS) and hospital at home services so that care for older people is responsive and delivered closer to home.

Protecting Adult Social Care:
Through the shift of resources brought about by the BCF plan, we intend to invest significantly (£9.35m) in adult social care services noting that higher rates of expenditure on social care is associated with lower levels of emergency admissions[6] which highlights the important relationship between local community needs for health and social care, and the role that social care can play in supporting people with complex health needs. The primary areas for investment include improving access to social care assessments, increasing the provision of domiciliary care, and enhancing the social care contribution to reablement services.

Based on our 6 design principles we have identified 11 schemes:
1. Expanding emergency Multi-disciplinary units (EMUs).
2. Enhancing reablement services.
3. Reducing delayed transfers of care.
4. Ambulatory emergency care pathways.
5. Integrated neighbourhood teams.
6. Care closer to home (advance care plans/End of Life Care and proactive medical support to care homes).
7. Hospital at Home.
8. Oxfordshire Care Summary: proactive care planning.
9. Protecting Adult Social Care.
10. Care Act Implementation.
11. Carers Breaks.

In addition we signal our intention to develop a range of ' **primary care**' schemes which are currently under development.

6 NHS England Characteristics and Trends at a National Level (March 2014).

b) What difference will this make to patient and service user outcomes?

We have aligned the things that patients' have told us are important to them as set out in our Joint Older People's Strategy, with our BCF schemes.

I can take part in a range of activities and services that help me stay well and be part of a supportive community.

Oxfordshire health and social care partners have successfully collaborated with the voluntary sector to provide preventive, 'well-being' initiatives. Recent developments include a falls prevention scheme, and 'circles of support'- a scheme offering a social network and practical support to older people and their families, to signpost and help them navigate the plethora of statutory and voluntary help available. In addition adult social care has invested in a Community Information Network to support this approach, and has made a significant investment in carers' support and services.

Furthermore it is proposed that the integrated neighbourhood teams will offer 'up-stream' support to individuals, through the proactive management of those with long-term conditions ,and by implementing early intervention strategies with those most at risk of admission. Together these strategies offer preventive means of halting deterioration, and enabling individuals to remain healthier and independent for longer.

I get the care and support I need in the most appropriate way and at the right time.

All of the 11 Oxfordshire BCF schemes are designed to promote the deployment of the right level of care and support at the right time. While neighbourhood teams will anticipate the care needs of individuals and act in a proactive way to prevent deterioration, the expansion of the EMUs will provide an appropriate response when older individuals become acutely unwell and/or require an urgent multi-disciplinary assessment. By building on the existing model already in operation, we will increase the numbers of individuals who can use the service as a more appropriate, alternative to the emergency department. Furthermore, the development of ambulatory emergency care pathways, will increase the opportunities for individuals to receive treatment as a day case when they are acutely unwell, and to be transferred back home with support as necessary, thus negating the need for a non-elective admission.

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.

Reducing delayed transfers of care is a paramount aim of the BCF plan. By signing up to the plan, the whole-system in Oxfordshire has committed to: improving the efficiency of assessments for frail, older

people; the early engagement of patients and their families regarding ongoing care options; and improving the consistency and continuity of clinical assessment standards. In addition collaborative working with the independent care and residential sector, should improve market management, and ensure that the Oxfordshire economy supports the sector to provide high quality, value for money care, that meets the changing needs of Oxfordshire's population.

As a carer, I am supported in my caring role.

Adult social care is preparing for the implementation of the Care Act 2014, from 1st April 2015 which forms part of our BCF plans for protecting adult social care. As a health/social care economy we will invest £1.35m, the greatest proportion of which will be directed towards paying for additional carers' assessments, as well as the delivery of new services to meet their needs. In addition we have a specific scheme relating to carer’s breaks which adult social care is already committed to.

If 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.

Oxfordshire has consistently demonstrated commitment to supporting people to have choice and control over the services/support they receive. For example, we have high numbers of older people who have a personal budget and high numbers of people who have decided to take their personal budget as direct payment.

With higher than national average population growth in people over 75 years anticipated over the next 25 years, continuing to support individual choice and control over services for those with dementia, will become an increasing local need and challenge. Through our plans for better managing the independent sector market, we will jointly commission a wide range of domiciliary and residential care facilities that will be directed towards meeting this need.

I see health and social care services working well together.

Health and social care services have an excellent track record of working in partnership. There are also well established pooled budget arrangements between the OCCG and the County Council across learning disabilities, physical disabilities, mental health and older people, which total £330m per year. The use of the pooled budgets is directly linked to the implementation of the joint commissioning strategies for the respective client groups, with strong governance arrangements that allow resources to be used flexibly to meet need and demand.

We will build on this track record of partnership through our BCF plans, noting that all 11 of our schemes are based on an integrated approach, which requires partnership and mutual co-dependence for holding all parties to account for delivery.

We will monitor improvement against these outcomes as part of our System

Resilience Group (SRG) dashboard. We recognise that our current suite of key performance indicators (KPIs) may not encompass all the challenges we currently face, and our intention is to add new KPIs to the dashboard as each new scheme goes live. In addition all partners have signed up to the following ambitions:

- i. More people 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
- ii. Everyone will be given the opportunity to voice their opinions and experiences to ensure that services meet their individual needs
- iii. The best possible services will be provided within the resources we have, giving excellent value for the public
- iv. We will be delivering fully integrated care, close to home, for the frail elderly and people with complex multi-morbidities.
- v. We will 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.
- vi. We will support choice and control in the belief that people themselves, regardless of age or ability, are best placed to determine what help they need.
- vii. We will routinely enable people to live well at home and to avoid admission to hospital when this is in their best interests.
- viii. We will continue to provide preventative care and to tackle health inequalities for patients and carers in both our urban and rural communities
- ix. We will 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.

c) What changes will have been delivered in the pattern and configuration of services over the next five years, and how will BCF funded work contribute to this?

The focus for the Oxfordshire whole-system is to enable people to live independently and well for as long as possible, using the widest range of mechanisms and support options available. This means we need to have joined up care that provides better care at home and reduces unnecessary time spent in hospitals and care homes. In line with the principles of the BCF, we want to ensure that both hospital and residential care are seen as 'admissions of last resort', with accessible alternatives at earlier stages. The 'golden thread' of our BCF plan is an emphasis on ensuring the right care in the right place, first time, and establishing the vital links between primary and community care, and acute hospitals.

Urgent care.

Over the next 5 years our plans will reduce the need for care in acute settings. A&E attendances and avoidable emergency admissions will reduce by 2% across our 2

main acute hospitals as community teams provide more targeted support to those at risk.

In September 2014 our urgent care systems were reviewed by the NHS England Emergency Care Intensive Support Team (ECIST) and their recommendations to improve the internal transactional processes within OUH, and whole system on a transformational basis, have been weaved into our BCF plan. In particular our plans for increasing EMU services and reablement will provide a responsive alternative to A&E, and increase short term interventions that rehabilitate people, restoring health and independence.

Through the development of community services within our neighbourhood teams, when an individual does need acute care they will stay in hospital for shorter periods, returning home safely with the help of services such as ‘hospital at home’ and enhanced discharge support. In addition our plans to expand the range of ambulatory care pathways will enable many patients requiring acute care to be seen, treated and discharged with 12 hours.

Our plans to enhance out of hours services working collaboratively with primary care, will enable 7 day working across health and social care services. Our population will no longer have to rely on A&E as their most reliable source of urgent response 24/7.

Over the next 5 years we will have resolved our enduring challenge in respect of DToC. We will have fully implemented all the current actions within our DToC plan, which we anticipate will reduce our average DToC from circa.151 to less than 100. We will continue to develop the plan recognizing that reducing DToC is at the heart of improving patient quality, and reducing the cost of care across the system.

Enhanced domiciliary care, and care homes working in partnership with statutory agencies, will enable early (and/or weekend) hospital discharge. In particular we will have finessed our ‘Discharge to assess’ programme, thus ensuring that assessments upon discharge take place in the right environment, at the right rime and maximize the patient’s opportunities to be as independent as possible.

Integrated Community Locality Teams.
More care for older people and people with long term conditions will be delivered through locality-based multi-disciplinary neighbourhood teams, with a lead professional responsible for co-ordinating the care of individuals, ensuring an integrated and personalised approach to case management, by all services working with each person - GPs, Community Health, Social Care, Housing, Mental Health workers and hospital services.

The emphasis will be keeping people well in their own homes, and maximizing independence by offering early intervention to prevent deterioration through 7 day services operating 24/7. Capital funding will be used by District Councils to support adaptations to property, to support people to stay at home (Disabled Facilities Grants), and additional capital funding will be used by adult social care to implement a new adult information system.

Initiatives to help people live safely at home, such as telecare and telemedicine, will

be deployed alongside more integrated and coherent approaches to preventative services, such as the voluntary sector initiative for overcoming social isolation.

For those most at risk of an emergency admission in our community, our 'closer to home' scheme will target those who are frail including those with dementia, by putting place anticipatory care plans and care co-ordination. This support will be enhanced for care homes, where investment in proactive medical support will improve medicines concordance, identify the early warning signs of health decline, and better support care home staff to deliver high quality end of life care. The rolll-out of the Oxfordshire Care Summary will improve shared professional access to care plans and essential patient information.

The balance of social care will shift even further away from care homes towards support in people's own homes, and supported housing schemes. Extra care housing is intended to provide an alternative to the use of care homes and enable older people to live independently with 24 hour on site care and support. It is forecast that 4,500 extra care housing flats will be needed by 2026 (OCC Market Position Statement). The staffing costs of these schemes are met from the home care budget.

OCC has set aside a capital grant allocation of £10.5m to help stimulate the supply of extra care housing between 2010 and 2016. This includes a number of schemes that have already been developed / opened and are operating successfully, and several schemes in the pipeline. In total, 813 extra care housing units will have been delivered by April 2016.

Home care services will be commissioned and resourced with a view to radically improving quality and outcomes, with home carers linked in with other health and care professionals, through the multi-disciplinary team approach. There will be enhanced support for carers in line with our Carers Strategy, and the Care Act

Federated Primary Care.
The Oxfordshire health and social care system is committed to enhancing the important role of primary care and a range of schemes are in the process of being developed working in partnership with GPs through the Local Medical Committee (LMC) and Principal Medical Limited (PML). We are currently developing plans to improve the primary care response to escalation, and in addition we are developing a bid for the Prime minister's Challenge Fund. At this stage our plans are in the early stages of development and are yet to be fully consulted on with our GP colleagues. So far our Prime Ministers Challenge Fund bid includes:

- **Complex care teams** – GP-led teams that will maintain personal care plans and support urgent assessments before 1pm when required.
- **Sub-locality hubs** – Collaborative working between practices that will increase capacity for same day assessments and enable GPs to have more clinical facing time with those who have long-term conditions.
- **Improving health literacy** – Ageneral practice interactive web-based health site providing specific condition guidance and sign-posting to other support.
- **Extended access hours i.e. linking out of hours to primary care escalation** – Enabling GP services to be available across the county from 8am – 8pm. and use of

duty doctor at practices closest to A&Es to support A&E turnaround and offer patients alternative to A&E attendance.

- **Support of early discharge -** By undertaking home visit on the same / next day of higher acuity patients released from bedded care

Furthermore the adult social care plan, includes provision for each general practice to be assigned a named social and community healthcare link worker. The Emergency Duty Team (out of hours OCC social work response), together with a review of control centres for safeguarding, EDT, crisis, telecare and equipment provision, will ensure a consistent social care response to primary care requests for out of hours social care support.

3) Case for Change

Please set out a clear, analytically driven understanding of how care can be improved by integration in your area, explaining the risk stratification exercises you have undertaken as part of this.

The primary drivers behind our BCF plan are the failure of the system to consistently achieve the 95% A&E target, and our enduring challenge with unacceptable delays in transfers of care from acute bedded provision.

In order to tackle these issues, our risk stratification exercises have identified the importance of:

- Population growth in those aged 65 and over.
- The top 2% of patients (9,700) identified as most at risk of emergency admission using the ACG risk stratification tool.
- Disease prevalence across Oxfordshire against the 9 of the top 12 ACSCs which have been shown as having a significant impact on emergency admissions.
- The role of integration across services: to improve locally provided responsive and preventive care; to build community resilience and self-care management; and to enable earlier discharge from acute care.

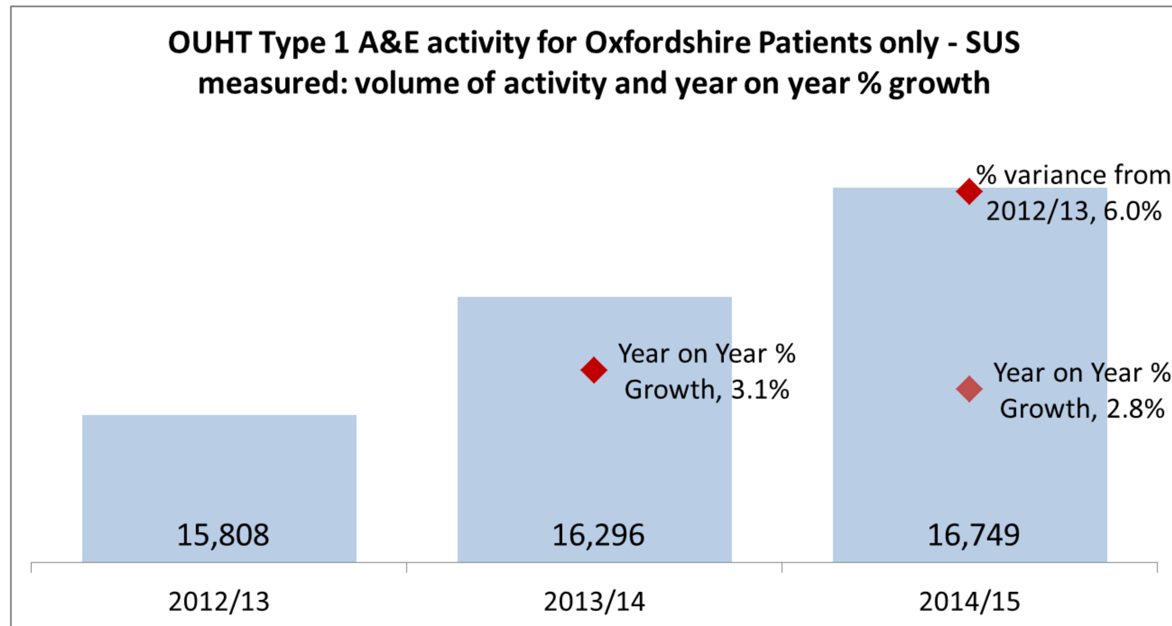
Our 2% target to reduce non-elective admissions.
Our work on locality planning has identified that the County of Oxfordshire has historically been one of the lowest nationally, in terms of the volume of non-elective admissions per 1000 population.

The NHS England published 6% percentage reduction in non-elective admissions applied to OCCG for 2012/13 - 2013/14, does not accurately reflect the 'real' trend in activity. If one takes account of the activity transfer for commissioning specialist services to NHS England, the 'true' trend was around 0.7% reduction. Our local data analysis suggests that non-elective activity has grown by 1% annually for the last 5 years.

Actual OCCG data for 2014/15 (extrapolated to month 7) shows a 4.5% increase in non-elective admissions to the comparable period above. To achieve a 2% reduction from this inflated baseline would therefore require a 6.5% reduction. We believe that 2% is both realistic and a stretch target.

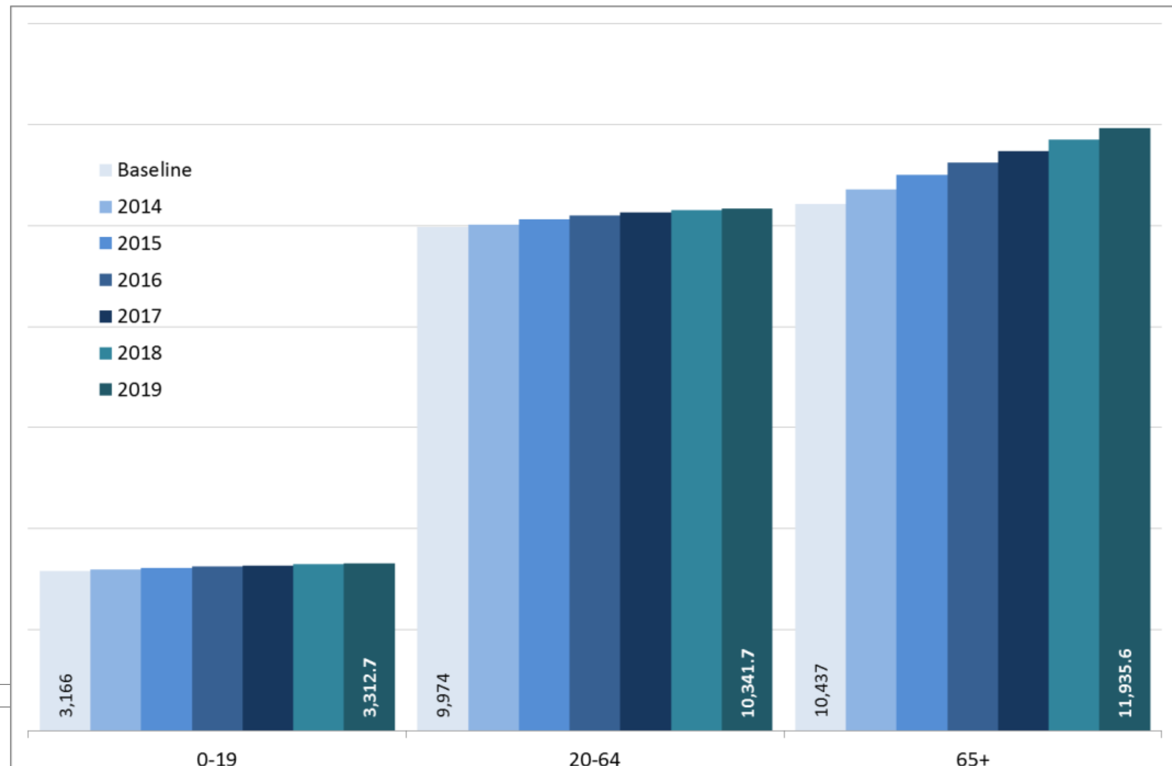
Population Growth.
Rates of A&E activity have continued to rise over the last 5 years (between 3 and 5% annually) and in 2014/15 are showing a significant increase on previous years (6% from 2012/13: table 1). The primary driver is thought to be the significant increase in the over 65 population which is increasing at an average rate of 1% per annum. Further work is underway to assess the impact of 111 on A&E activity to see whether the service has had an adverse or positive impact on reducing attendances.

Table 1



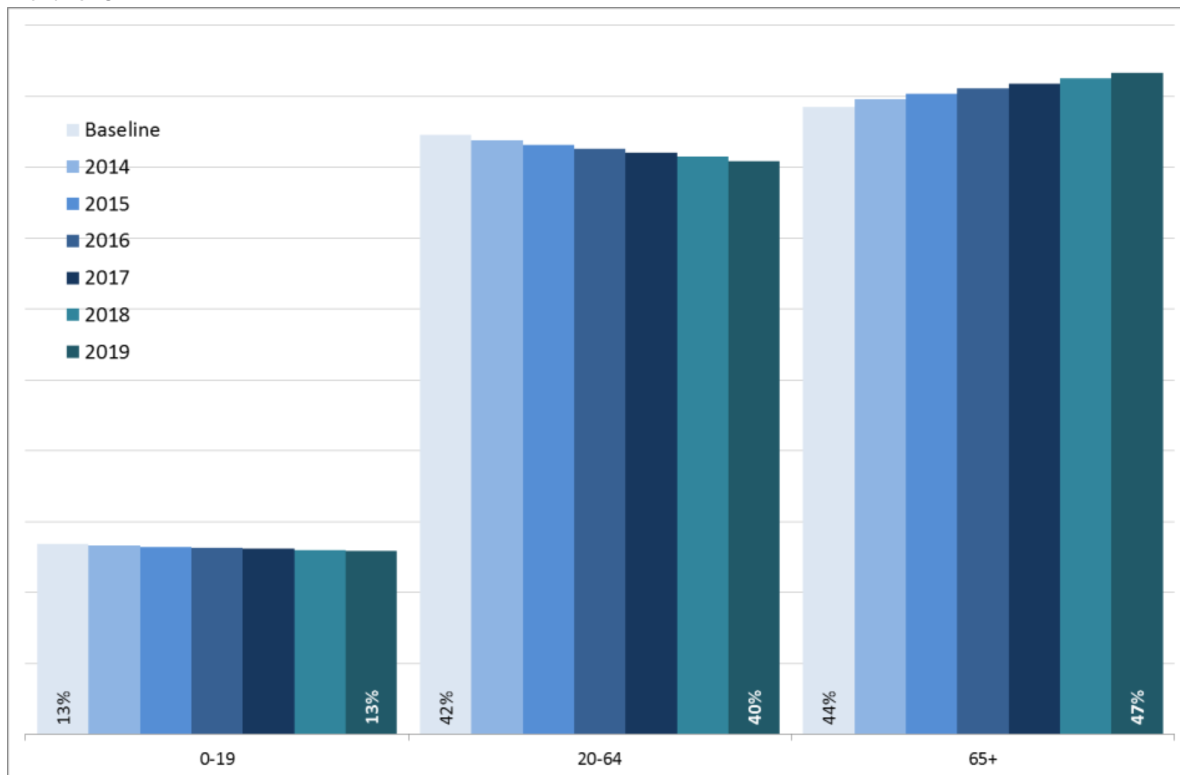
Clearly Oxfordshire, like many other areas in England, will see the impact of an ageing population on health care consumption and a risk of significant growth in the volume of non-elective admissions. This has been modelled in table 2 below.

Table 2



Consequently, the proportion of healthcare expenditure on the over-65 population is set to increase as shown in Table 3.

Table 3



Disease Prevalence across Oxfordshire

OCCG has made a critical review of the local and national experience in improving the management of emergency care. The lessons are common between the King's Fund Review on 'Avoiding Hospital Admissions' (December 2010) and the Keogh Urgent & Emergency Care Review, three years later - that an integrated approach between health and social care (and between professionals in different disciplines) is essential if seamless care is to be provided before a crisis develops, at the time of crisis, and following emergency intervention (most frequently, a hospital admission).

OCCG has commenced with a review of its 6 localities, led by locality commissioning directors as local GPs, and informed by the JSNA and working experience of recent operational resilience capacity planning (ORCP) programmes. This has identified target populations within key wards, for whom crisis intervention would be particularly appropriate, and is in line with the Kings Fund recommendation to focus on patients within the lower socio-economic groups.

A national initiative to identify the top 2% of patients at risk of hospital admission, has enabled OCCG to address the next key recommendation - "in primary care, higher continuity of care with a GP is associated with lower risk of admission" – since the majority of care-plans completed have identified the GP as the key care co-ordinator. This has been carried out by all practices across Oxfordshire using the ACG Risk Stratification Tool to identify:

(a) patients at high risk of deterioration and subsequent escalation in the

community;
(b) patients who are frequent attenders in acute services, either via attendances or emergency admissions.

In addition differences in disease prevalence between the top 5% highest risk and the rest of the population have also been analysed, comparing the prevalence of the 12 ACSCs (5 long-term conditions ACSCs and 7 acute ACSCs). It has proved possible to derive the equivalent of 9 of these, and subsequently we are aiming to support an 'at-risk' target population in the region of 9,700 patients with anticipatory care plans as part of our 'closer to home' scheme. In addition the 12 ACSCs are the subject of improvement within our ambulatory emergency care scheme.

Integrated Care.
The King's Fund Review has informed local inter-agency analysis of integration models, comprising models of 'vertical integration' (between community and hospital), and 'locality integration' (between primary and social care).

The King's Fund Review demonstrates that both of these models are necessary measures in tackling emergency admissions, with implications for managing frequent attenders, through a personalised health care programme, and for ensuring that discharge-planning is structured, with sufficient risk-assessment of the client to prevent early re-admission. This evidence underpins our principle assumptions regarding the important role of integration, and as a consequence our plans to introduce integrated neighbourhood teams to Oxfordshire.

A key conclusion of the case for change work is that the current system is unlikely to address performance short-comings regarding the 95% A&E target and DToC without transformative change. The increasing proportion of older people is already having an impact on demand, and taken with the financial challenges facing the system, new ways of operating across the system will be crucial to ensuring that health and social care services are fit for purpose in the future. The evidence shows that integration can help bridge that gap by shifting the balance of care towards more preventative community based care, and in so doing improve outcomes. All partners agree that there is scope to improve services and reduce costs by better integrating services. Our risk stratification and population segmentation approach has led to an initial focus on older people and long term conditions, and this has informed the focus of the BCF.

The BCF is one part of the integrated response to making the required changes to achieve sustainability and improve outcomes.

4) Plan of Action

- **Please map out the key milestones associated with the delivery of the Better Care Fund plan and any key interdependencies**

This section sets out our change management plan to bring about transformation across the system. We will approach the implementation of the plan as a whole-system, monitoring progress and mitigating risks through the SRG. The development and delivery of the schemes highlighted in this plan, reflect the collective efforts of all partners and are evident in the individual strategies and plans

of all constituent parties. Every scheme has been assigned a project lead and is subject to the discipline of project management, through the programme management office in the OCCG.

All partners acknowledge their collective responsibility for improving DToC and achieving the 95% A&E target, and as a result all schemes represent interdependencies between two partner agencies or more for successful execution.

Reducing the proportion of patients who are inappropriately admitted to hospital requires the mobilisation of rapid assessment schemes, the earliest impact of which will come from the care closer to home initiatives (proactive medical support to care homes/anticipatory care plans) and ambulatory emergency care pathways. Plans to introduce integrated neighourhood teams will commence a phased introduction from June 2015, the full impact of which is unlikely until early 2016. Plans to increase EMU provision will commence towards the end of 2015/16. The significant interdependency for reducing inappropriate hospital admission lies with primary care and OUH. Ensuring that communication between GPs and medical consultants is timely and responsive is pre-requisite to this set of plans and will be monitored through SRG.

Reducing the proportion of people who spend longer in hospital than they need to is dependent upon the delivery of our DToC plan. This is truly a whole-system plan where interdependencies exist between OUH and all health and social care providers of ongoing care. Early implementation of DToC 'quick wins' relate to transactional improvements internal to OUH including implementation of the joint Choice Policy, improvement of the assessment process including earlier involvement of social care, continuing healthcare, medication to take home, and booking patient transport. With regard to ongoing care all providers have signed up to the concept of facilitating 69 discharges every day, broken down by service. Expansion of reablement services and protection of social care with an emphasis on doubling available domiciliary care over the 12 months, are critical factors where the acute sector is highly dependent on the OHFT and OCC mobilisation of their schemes.

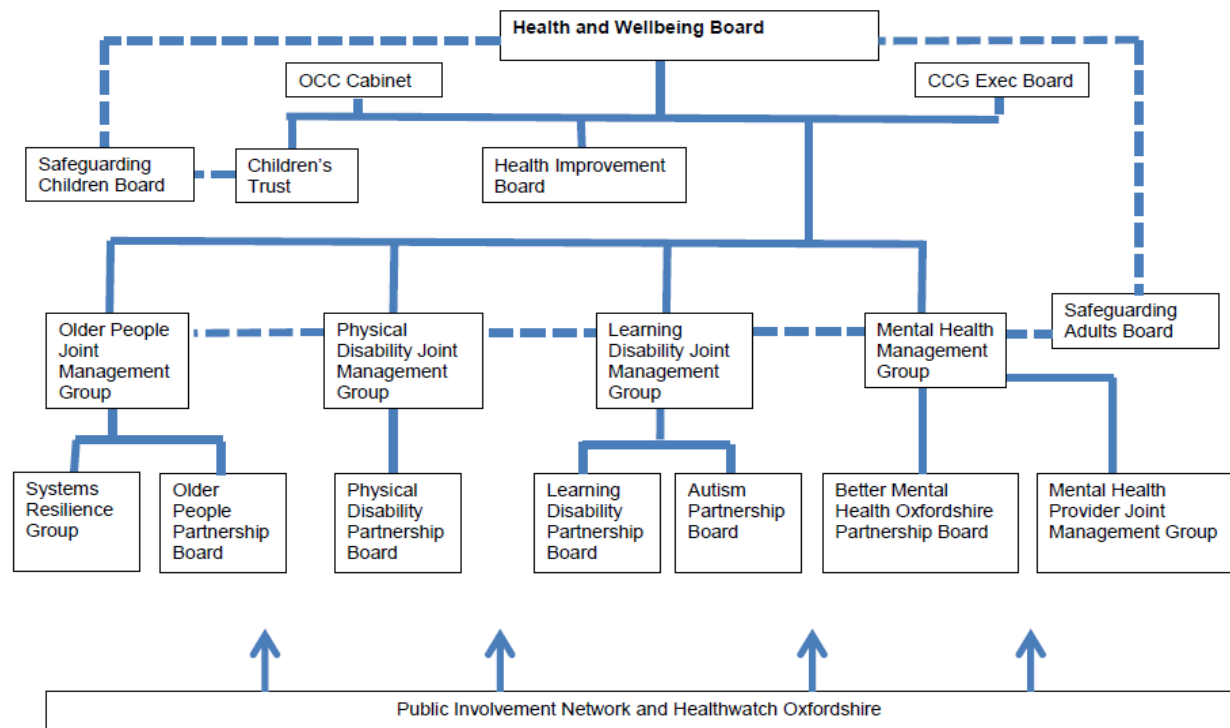
Reducing the proportion of people admitted to residential and care homes across Oxfordshire, is dependent on improving support to people in their own homes. Our plans for introducing neighbourhood teams is an essential component as is protecting adult social care. The interdependencies for the delivery of these initiatives are primarily with OHFT, primary care and OCC.

Milestone	Date	Comments
Finalisation of the BCF plan and paper to Health and Well-being Board.	29.12.14	
Sign off by Health and Wellbeing Board	08.01.15	
Submission of the BCF plan	09.01.15	
BCF plan endorsed by SRG	15.01.15	
ECIST action plan progress update to SRG.	15.01.15	
OCCG letter to all practices recommending the co-commissioning of primary care services.	January 2015.	In response to NHS England's invitation for expressions of

		interest in different models of co-commissioning.
Oxfordshire whole-system Urgent and Emergency Care Strategy 2015 – 2020 to SRG for approval.	12.02.15	
Single assessment process and supportive documentation capable of following the patient through their journey.	February 2015	Transactional improvements to the inpatient assessment process – including continuing care assessments.
Proactive Medical Support to Care Homes – investment for approval at CCG Clinical Executive	January 2015	Services commences February 2015
Prime Ministers Challenge Fund Submission	16.01.15	
DToC plan first quarterly performance update report to SRG.	March 2015	
Ambulatory Emergency Care pathways for 5 long-term condition and 7 acute pathways.	April 2015	Sign-off at Clinical Reference Group.
Comprehensive review and plan to take forward 'Discharge to Assess' to SRG for approval.	April 2015	
The establishment of an Oxfordshire Commissioning Board	April 2015	This will bring together OCCG, OCC and NHSE to ensure we join up the commissioning of all health and social care services for our residents.
First neighbourhood team up and running	June 2015	
All neighbourhood teams in place	Sept 2015	Location TBD
Reablement Plan to increase service by 50%, submit to SRG.	October 2015	
Streamlining reablement, supportive hospital discharge service (SHDS) and hospital@home.	October 2015	

- **Please articulate the overarching governance arrangements for integrated care locally**

The BCF plan is a whole-system joint plan which brings together all partners with joint aims and objectives to transform the system.



The Council and OCCG have agreed strong governance arrangements comprising the Health and Wellbeing Board (HWB) and joint management groups (JMG) which oversee the current arrangements for the pooled budget, currently £330m across older people, physical disability, learning disability, and mental health services. The JMGs involve commissioners, GPs, clinicians, NHS providers and service users/carers in decision making regarding use of the budget. In addition to accountability for the pooled budget, the HWB has overarching responsibility for signing off the BCF plan and will receive progress updates on a quarterly basis.

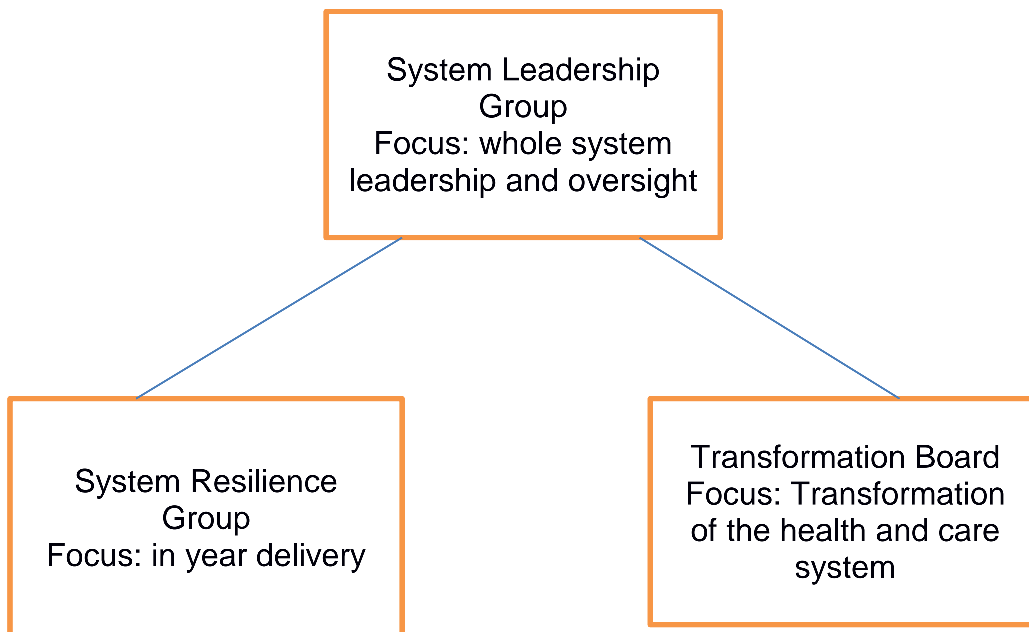
In addition the Chief Executives of the major Oxfordshire organisations (Oxfordshire Clinical Commissioning Group, Oxfordshire County Council, Oxford University Hospital Trust, Oxford Health Foundation Trust and Principal Medical Limited) have agreed a set of proposals for collective leadership of the health and social care system in Oxfordshire.

In governance terms the System Leadership Group sits alongside the HWB, and will provide whole system leadership and oversight for all joint plans and strategies including BCF and its links to operational resilience plans and QIPP. The 6 criteria that under pin our system leadership are as follows:-

- Establishment of core shared purpose,
- Shared understanding of when and for what services the system is operating in joint planning mode and where it is competing,
- Shared mechanisms for managing financial risk and benefit,

- Shared agreement upfront on the route for ultimate arbitration,
- A shared agreement on an underpinning clinical basis for any transformation
- Establishment of strong interpersonal relationships.

Our Systems Resilience Group (SRG) and whole system Transformation Board will be accountable to the System Leadership Group.



The System Leadership Group (SLG) will drive forward the transformation of the care system in Oxfordshire; managing crisis will that impact on the whole system; considering wider issues affecting the system as a whole (e.g. transport, economic development); maintaining an overview of the financial position of the system; and forward planning and managing the interface with governing bodies, the County Council and the HWB.

The Transformation Board comprising CEOs and direct reports (Chief Operating Officers, Director of Strategy, Director for Delivery) will bring together in one place all projects which will deliver significant change to the system. It will become the forum where new models of payment in the NHS, new models of provision (as detailed in the 5 year forward plan) and system enablers (E.G. workforce, IT and assets) can be discussed at length.

The System Resilience Group (SRG) compromising a similar membership as above, will provide operational and ongoing oversight of the BCF plans, ensuring that actions are implemented, with the capacity in place to do this effectively. The Transformation Board will ensure that our BCF plan is refreshed by future new innovations as they arise.

c) Please provide details of the management and oversight of the delivery of the Better Care Fund plan, including management of any remedial actions should plans go off track

The BCF plan will be managed through the SRG and associated delivery group

structures, with ultimate accountability to the HWB. Each BCF scheme has a clear plan setting out the service details, key deliverables in terms of activity and outcomes, named lead organisations and managers, risks, dependencies, milestones and reporting arrangements. These requirements will be reflected in the Section 75 agreement underpinning the governance of the pooled budget.

Quarterly exception reporting on all schemes will be required, although care will be taken not to add unnecessary or duplicated reporting burdens. This will feed into a quarterly report for the HWB to assess progress and discuss any areas that need unblocking.

For any scheme element that is not on track, a recovery plan will be provided. Particular focus will be given to spending and any variance on plans will be addressed, including consideration of the reinvestment of any slippage.

Outcomes will be managed at scheme level and whole-system level, with close performance management of key measures undertaken on a monthly basis, including analysis of avoidable admissions, care home placements and delayed transfers of care.

d) **List of planned BCF schemes**
Please list below the individual projects or changes which you are planning as part of the Better Care Fund. Please complete the *Detailed Scheme Description* template (Annex 1) for each of these schemes.

Ref no.	Scheme
1	**Emergency Multi-disciplinary Units (Expansion of an existing scheme)**: The proposal is to expand the existing EMU services in Abingdon and Witney, to two more sites in Banbury (Horton Hospital) and Oxford City (The John Radcliffe Hospital). In addition system partners are designing a 'virtual' EMU which will provide county-wide coverage, and rely on technological solutions, such as point of care testing, telemedicine and remote working technology, to enable frontline community healthcare professionals to access specialist medical and geronotogy diagnostics and advice, so that people can be cared for in their own homes.
2	**Reablement Services (Expansion of an existing scheme):** This is focused on increasing the number of people who could recieve reablement in the community. The system outcome is to reduce the long-term care needs of individuals. The focus of this scheme is to reappraise the multiple reablement services and existing pathways and seek to have one consistent pathway, assessment and process established.
3	**Reducing delayed transfers of care (New scheme)**: The Oxfordshire Delayed Transfers of Care (DToC) Plan sets out the priority goals, objectives and actions that will be enacted in 2015/16 and beyond to improve performance against DToC key performance indicators. In essence the whole-system in Oxfordshire is working in partnership to reduce the proportion of individuals delayed unnecessarily in an acute environment.

Ref no.	Scheme
4	**Ambulatory emergency care (New scheme)**: AEC Pathways are intended to manage patients presenting at an acute setting who require treatment, without requiring admission. Patients are managed in a specific area with full access to diagnostics, medical advice and care with the intention that they will be appropriately discharged into the community as soon as possible.
5	**Integrated neighbourhood teams (New scheme)**: This scheme focuses on bringing professionals together to deliver joined up personalised integrated care to patients in the community. The system outcomes are improved population health, efficiency and effectiveness gains, and reduced service use through improved health and social capacity.
6	**Care closer to home (New scheme):** This scheme is about ensuring that our most frail citizens have access to appropriate care closer to home, in way that prevents unnecessary admission and improves the quality of End of Life Care. The scheme pulls together a focus on our top 2% most at risk of a non-elective admission. This scheme is not just patients in care homes, although a significant proportion of frail, elderly citizens are resident in care and nursing homes.
7	**Hospital at home (Expansion of an existing scheme):** This scheme is about expanding the provision of Hospital@Home, essentially delivering across the whole county 24/7, to maintain peoples care within their own home, through a sub-acute episode of need, for up to 14 days, including: • rapid community assessment and intervention to avoid acute admission, • nursing intervention to facilitate and enable timely discharge from acute admission, • holistic care that promotes and supports individuals in maintaining their independence.
8	**Oxfordshire Care Summary - proactive care planning (Existing scheme):** The proactive care planning scheme will: • Enable the capturing of the care planning data set in GP systems by means of a clinical template. • Enable the sharing of the care planning data set to the Oxfordshire Care Summary by means of requesting the approved Read codes from the data supplier. • Enable the most effective presentation of the care planning data set by means of liaising with urgent care clinicians to develop the display within the Oxfordshire Care Summary • Promote the posting of care documents such as DNACPR forms for sharing via the OCS. • Promote the use of the Oxfordshire Care Summary across health and social care providers in Oxfordshire. • Seek clinical data from other providers as soon as it is available in order to increase the breadth and depth of the data set and to reduce the risk

Ref no.	Scheme
	of processing errors in the information chain.
9	**Protecting adult social care (Existing scheme):** The focus of this scheme will reducing 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. The focus in particular will be on frail older people with investment focused on: • Long term care packages, • Equipment, • Intermediate care including reablement, and • Services to support discharge.
10	**Care Act Implementation (Existing scheme):** The Adult Services Improvement Programme is responsible for the implementation of reforms resulting from the Care Act. The programme includes a range of projects and developments specifically targeted at meeting the demands of the reforms, including: • improving provision of online, telephone and face to face information and advice, including for self-funders, • developing a model of self-assessments, and development of an e-marketplace to drive choice and control for individuals, • further support for carers in line with their right to access services, and meeting the anticipated increase in demand for assessments, building on existing services including carers breaks, • improving existing processes and systems to avoid duplication and make them as effective as possible, including a new IT system for Adult Social Care, • developing new ways of working that support integration, including devolving responsibility to locality teams, • developing the local market to better meet the needs of individuals, • ensuring the social care workforce is suitably trained, skilled and rewarded.
11	**Carers Breaks (Existing scheme):** This scheme encompasses a range of initiatives designed to support carers to continue to play an essential role in the development of health and social care services in Oxfordshire.

In addition to the 11 schemes detailed above, OCCG has signalled commitment to supporting a range of GP-led initiatives designed to extend GP services and improve the patient's experience of primary care. Collectively the initiatives will:

- improve education and support to people with long-term conditions to promote self-care management;
- respond urgently to prevent deterioration in those with a known long-term condition; increase primary care provision during periods when the health and social care system is experiencing significantly increased pressure according to the Oxfordshire Escalation Framework; and

- support improved flow through bedded care and offer alternatives to ED attendance and admission.

5) Risks and Contingency

a) Risk log

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 and any financial risks for both the NHS and local government.

The risk assessment below was conducted by the SRG in December 2014. It highlights what all partners believe is a realistic assessment of extent of the challenge to transform the system, across Oxfordshire.

There is a risk that:	**How likely is the risk to materialise?** *(1 low-5 high)*	**Potential impact** *(1 low-5high)*	**Overall risk factor** *(likelihood *potential impact)*	**Mitigating Actions**
Lack of consensus on the key constraints facing the system and the solutions to address them could be caused by lack of system leadership.	3	4	12	The convening of the System Leadership Group (SLG), with the SRG and the Transformation board at a sub level **(December 2014).** Attendance will be recorded and reviewed by the SLG on a quarterly basis.
Non-delivery of acute emergency demand reductions results in OCCG deficit, non-delivery of community investment and capacity problems in the acute sector	4	3	12	Progress on impact on acute demand reductions will be monitored closely as part of the BCF governance arrangements through the SRG and recovery plans put in place promptly where necessary. If targets not met, contingency plans to set out how any excess acute demand will be funded whilst protecting the development of community based services.
Failure to address current system failings such as delayed transfers of care and crowding in the emergency department through lack of whole-system collaboration on a joint vision and strategy for urgent and emergency care.	3	5	15	The development of a whole-system strategy for urgent and emergency care to be approved at the SRG **(February 2015).** A strategy for delayed transfers of care was approved at SRG **(December 2014).** A Joint Escalation Policy has been cited at the December SRG and will be formally approved at the SRG **(January 2015).**
Patients are at risk of harm	3	5	15	Full implementation of the joint Choice

There is a risk that:	How likely is the risk to materialise? *(1 low-5 high)*	Potential impact *(1 low-5high)*	Overall risk factor *(likelihood *potential impact)*	Mitigating Actions
through infection and other complications, and deterioration in their activities of daily living brought about by delayed stays in inpatient care (predominantly acute inpatient stay).				Policy **(January 2014).** The development of DToC and associated KPIs **(January 2015).** The development of an acute/community single assessment process for frail older people, with single documentation and consistent clinical assessment standards **(February 2015)**. The development of a homeless discharge pathway working with key homeless charities in Oxfordshire **(May 2015)**. The development of a housing assessment pathway to ensure that an individual's housing needs are considered as early as possible, preferable before deterioration and an emergency admission are inevitable **(January 2015).** Taking steps to improve market management of independent care and residential agencies, and ensuring the risks and pressures that face this industry are understood as part of the whole system in Oxfordshire **(January – October 2015).** A review of reablement services to increase the proportion of people who access reablement including streamlining of current rehabilitative, closer-to-home services **(April 2015).**
Avoidable non-elective admissions continue to increase in the absence of whole-system formalized care pathways focused on Ambulatory Emergency Care pathways -	4	4	16	Refinement of ambulatory care KPIs for SRG dashboard **(January 2015).** Long-term ambulatory care sensitive conditions (ACSCs: COPD; Atrial fibrillation and flutter; Asthma; Heart failure; and Angina pectoris developed and agreed **(April 2015).** Acute ACSCs to be developed and agreed: UTI; Lobar pneumonia (unspecified);Diarrhoea and gastroenteritis of presumed infectious origin; Upper respiratory infections (multiple and unspecified sites); Convulsions (not elsewhere classified); and Viral and other unspecified intestinal

There is a risk that:	How likely is the risk to materialise? *(1 low-5 high)*	Potential impact *(1 low-5high)*	Overall risk factor *(likelihood *potential impact)*	Mitigating Actions
				infections **(April 2015).**
Failure to safeguard patient safety, maintain effective patient-flow and meet statutory urgent care targets, due to ineffective response across health and social care organisations to increased volume of demand or reduced capacity for urgent care.	4	5	20	Implementation of the Escalation Policy (**January 2015).**
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	3	5	15	**(January – March 2015)** The care and residential sector to be seen as an integral and equal whole system partner alongside statutory agencies. Equal understanding of costs and pressures alongside statutory agencies. Analyse data by parent company to understand volume and costs of placements. Carry out Kraljick analysis to understand the suppliers with which we can develop a strategic partnership. **(April – July 2015)** Improvement of rates through commercial negotiations as well as to ensure timely assessments, transfer and interface with health care. Agree SLA to complete assessments in a timely manner with strategic partners. Review level of care provided under domiciliary care block contracts.
Insufficient 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	3	5	15	Workforce plan in place to addresses issues of low pay and access to adequate training and clinical supervision **(March 2015).** Mandatory requirement that all staff have safeguarding training **(March 2015).**

There is a risk that:	How likely is the risk to materialise? *(1 low-5 high)*	Potential impact *(1 low-5high)*	Overall risk factor *(likelihood *potential impact)*	Mitigating Actions
				Support care/nursing home sector to introduce value- based recruitment **(March 2015).**

b) Contingency plan and risk sharing

Please outline the locally agreed plans in the event that the target for reduction in emergency admissions is not met, including what risk sharing arrangements are in place i) between commissioners across health and social care and ii) between providers and commissioners

Our BCF plan identifies that transformational approaches will drive how the system manages care demand across health and social care services over the next 5 years and beyond. All partners recognize that success in facing up to the Oxfordshire challenges, will only be achieved by operating at a whole-system level, working collaboratively, supporting co-dependencies and managing risks across organizational boundaries.

This is an ambitious target given the historic annual growth in A&E and non-elective activity. We anticipate that the impact of some of our schemes will manifest early in 2015 (e.g. the DToC plan). However the impact of some of our more transformational approaches (e.g. neighbourhood teams) may not be material until well into 2016. Delays in the delivery of plans that are expected to materially deliver the 2% reduction in non-elective admissions, is a risk that the system acknowledges.
Management of risk, at both a clinical (patient) level and systemic (organisational) level, has been a key focus for OCCG and our partners. Development of the BCF plan has enabled us to test a dynamic model of financial investment in specific care-models, correlated to the acceptance of risk by providers if the proposed changes fail to deliver the anticipated benefits for reducing non-elective admissions, reducing DToC and enabling the system to achieve the 95% A&E target.

This is being developed further through the outcomes-based contract for older people (and for adult mental health services), focused on integration across the patient pathway to improve patient care and outcomes, with delivery of improved performance, directly related to contract incentives, using patient acuity measures such as the Hurst tool, alongside activity markers. Hence the system will gain a greater understanding of the level of patient dependency/acuity alongside anticipated reduction in activity.

The system plans to share the financial risks by incorporating the BCF into existing pooled budget arrangements. This is a well-established mechanism in Oxfordshire, through which the shared risk is proportional to the input from OCCG and the Council. The risk share within the s75 NHS Act pooled budget arrangement is set out in the main agreement and in the Schedule 1 thereto. Together the Council and OCCG have mature risk sharing arrangements which are used to protect adult social care. Currently the pool

represents one quarter of the OCCG budget and 99% of adult social care budget.

All health and social care organisations have committed to the development of joint QIPP plans via the Transformation Board. Initial discussions have been held across the health and social care economy regarding a feasible and equitable approach to risk-sharing. These will continue.

The system resilience initiatives are closely aligned to the BCF approach and it is at SRG that the performance of the BCF plan will be robustly monitored. The SRG dashboard and risk register are the central mechanisms for reporting performance against KPIs and managing the risks of non-delivery. It is from here that the system will become alerted to the earliest signs of targets not being met, so that recovery plans can be put in place.

6) Alignment

a) Please describe how these plans align with other initiatives related to care and support underway in your area

The current vision for Oxfordshire through to 2019/20 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 for 2014/15-2018/19. This strong alignment between existing strategies and plans will be further enhanced by the agreement of a single strategy for the health and social care system in Oxfordshire by March 2015.

Plans relating to BCF have been developed as the result of the whole system facing up to disappointing performance across the 95% A&E target and DToC. This has brought together collective plans for improvement including:

- QIPP proposals across the whole system for delivery in 2015/16 linked to the BCF plan. Specific areas include the ambulatory care pathways and 'care closer to home' initiatives in support of our most frail residents and end of life care.
- a joint submission under the 'most capable provider' guidance for older people's services from OUH and OHFT (under OCCG consideration),
- a joint plan to reduce DToC developed by all health/social economy parties including representation from the independent care sector,
- joint policies for improving the system such as the joint 'patient choice' policy and 'escalation' policy.
- Collaborative working to develop an action plan in response to ECIST recommendations, involving all providers and commissioners across health and social care, and
- Our joint operational resilience capacity plan (ORCP) which monitored via the SRG.

b) Please describe how your BCF plan of action aligns with existing 2 year operating and 5 year strategic plans, as well as local government planning documents

The CCG's Operating and Strategic Plans have indicated our commitment to the key objectives stated in Section 2(c) (Vision for Services), namely:

- Locality Integration across Oxfordshire – for primary, community and social care
- Vertical Integration – for secondary and community, and including an extension of re-ablement programmes, reductions in admission to acute, community and intermediate care, and reductions in length of stay
- Outcomes-based contracting for older people (and for adult mental health services)

These intentions are also echoed in Oxfordshire County Council's Adult Social Care Business Strategy for 2014/15 and beyond, and restated in the Oxfordshire Health & Wellbeing Strategy.

The BCF plan brings the aspirations contained within the 5 year strategic plan, into tangible, realistic and deliverable objectives which will be incorporated into a refreshed 2 year plan (annual operating plan 2015/16), and subsequently be revised in the context of each subsequent year of delivery over the next 5 years, as part of the OCCG annual planning cycle.

An example of alignment between the BCF, the adult social care plan and the health and wellbeing strategy (HWBS) can be seen in the development of integrated neighbourhood teams - a new scheme in the BCF. The HWBS is explicit about improving support for adults with long term conditions. In part this will be enacted via improving social care support, particularly in meeting the needs of carers, and via improving the primary care response to managing long-term conditions in the community. The HWBS also prioritises the needs of older people to live independently whilst reducing the need for care and support. Again our plans to introduce integrated neigbourhood teams supports this priority, as does adult social care plans to increase reablement provision and domiciliary care.

We expect our BCF plan to reviewed each year by all system partners, so that our collective annual plans are informed by up to date performance against our BCF targets, and stretched by our ambitious future plans for transformation.

c) Please describe how your BCF plans align with your plans for primary co-commissioning

- **For those areas which have not applied for primary co-commissioning status, please confirm that you have discussed the plan with primary care leads.**

By April 2015 we will be establishing an Oxfordshire Commissioning Board which will bring together OCCG, OCC and NHS England to ensure we join up the commissioning of all health and social care services for our residents.

In preparation for this and throughout 2014/15, OCCG has undertaken a number of

functions jointly with NHS England in shadow form. These functions include:

- establishment of a development board with representation from NHS England, OCCG, Healthwatch Oxfordshire and LMC to lead the strategic development of primary care
- development of a joint local improvement scheme for general practice linked to the Proactive Care DES, with joint monitoring processes established with Thames Valley Area Team
- liaison with practices whose income have been significantly reduced either as a result of loss of MPIG or PMS premiums to assess the impact on the wider health system
- monitoring the quality of general practice services through the national GP survey, CQC inspection reports, achievement of prescribing targets etc., and using peer review and support in locality meetings to share good practice and reduce unwarranted variation
- supporting collaboration between practices, resulting in the formation of seven primary care federations which together represent 74 out of 82 practices across Oxfordshire
- development of an integrated model of diabetes care which will increase management of people with unstable diabetes in locality hubs with care provided by multi-speciality teams including consultant advice, diabetes community nursing, prescribing and GP expertise. This is expected to impact on numbers of emergency admissions for patients with severe diabetic complications (e.g, neuropathy, podiatry and ophthalmology). Although these numbers will be small, and not directly within the remit of the BCF, the development of such tier 2 services with care provided by primary care in partnership with community and acute providers offers a model for more proactive, community based management of people with long term conditions.

Initial discussions with OCCG Locality Clinical Directors indicate that the OCCG will wish to formalise this joint commissioning approach in its response to NHS England's invitation for expressions of interest in different models of co-commissioning. Going forward we will be recommending to practices that OCCG go for the co-commissioning of primary care services and letter detailing this will be sent to all practices in January 2015.

7) National Conditions

Please give a brief description of how the plan meets each of the national conditions for the BCF, noting that risk-sharing and provider impact will be covered in the following sections.

a) Protecting Social Care Services

i) Please outline your agreed local definition of protecting adult social care services (not spending)

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.

Local Authorities have a statutory duty to meet the needs of older, disabled and vulnerable people and their carers - this includes older people, adults with learning disabilities, adults with mental health problems and those with physical and sensory impairments. Social care needs are, in summary, activities of daily living, personal care such as going to the toilet, help with bathing and eating and in some circumstances help with occupation and activities during the day (for example for younger adults who may require access to training and employment). Access to support is normally through a professional assessment of need, guided by nationally set eligibility criteria. Local authorities can take resources into account when determining how those assessed needs should be met but we cannot refuse to meet people's eligible care needs.

ii) Please explain how local schemes and spending plans will support the commitment to protect social care

Adult social care is under significant pressure and the County Council under even greater pressure because local government has been targeted for much larger public spending reductions than other parts of the public sector. However, the County Council has fully funded the impact on demographic pressures on adult social care. By 2017/18 the County Council will have invested £35m annually since 2010. Of this, £15m will have been invested in services for older people and £20m in younger adults.

The investment is one of the reasons why the County Council has to make savings of £260m annually by 2017/18. Within this total, adult social care will have made savings of £50m annually – approximately ¼ of the total adult social care budget and one-fifth of the total savings required of the County Council.

As a result of the investment in demography and the fact that adult social care has made proportionately fewer savings than other services, the proportion of the Council's budget that is devoted to adult social care has increased from 37% in 2011/12 to 42% in 2014/15 and will increase still further in the future.

Through the Better Care Fund, there will be an additional £8m contribution to protecting adult social care services in 2015/16. This will be on top of the current transfer of £10.5m from NHS England to Adult Social Care that will also form part of the Better Care Fund from next year, and the £1.35m for implementation of the Care Act (in line with national allocations)

The identified schemes protect adult social care through investment in improved delivery, through enhanced pathways that move clients in to more cost effective care pathways, and through the creation of increased flexibility in budgets enabling the identification of shared benefits.

Investments in an improved reablement service, and supported hospital discharge service, mean that patients will receive appropriate preventative reablement in the community and will be supported out of hospital in a way that ensures effective

functional improvement in ADL performance. Alongside improved clinical outcomes, this both reduces pressure on acute services – as effective community reablement reduces admissions – and reduces the amount and length of both home care and care home provision – as people are more able to manage independent. This combination of improved patient outcomes, decreased pressure on acute services, and reduced social care cost characterises the overall choices that Oxfordshire have made when reviewing decision about spending Better Care Fund funding.

Enhanced pathways that support and protect adult social care are, for example, the investments identified to support both the delivery and management of care in care homes. Both of these increase quality and reduce admissions. The Care Homes Support Service engages proactively with care homes providing nursing input to improve the quality of care and reduce health risks to patients. This has recently expanded to provide additional dementia support. OCC joint commissioning work closely with care homes and through the provision of leadership, contract management and contract monitoring of services improve quality. The shared work of clinical support through primary care, of contract and quality management through OCC, and of nursing support through OHFT provide a coherent scheme targeted at increasing the quality of life of people in care home, and thereby extending healthy life and reducing admissions.

The Council is currently developing a new strategic approach to the future delivery of home care. A 'Help to Live at Home' service will be procured during next year to replace the existing interim block contracts from April 2016. The intention is to have a framework contract of about 10 to 15 providers that guarantees a minimum level of business, subject to delivery. The Council will introduce an outcomes based approach, including incentives for providers to help people achieve greater independence so that they can remain living at home. Furthermore, providers will be contractually required to meet certain workforce expectations including the payment of travel time and travel costs.

Flexible budgets have enabled the Older People's pooled budget 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. 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

There is also clear evidence of the benefits of adult social care spending in saving costs elsewhere in the system. For example, the Alert Service is a countywide service providing telecare alarm equipment to vulnerable and older adults that will continue to be funded through transfer from NHS to social care under this plan. In September 2013, a review found that 39% of calls to the service were because the client was ill or had fallen. In 99% of these cases, the mobile responder was able to deal with these themselves, and in only two cases did the responder need to refer for an ambulance. At a cost per call-out of approximately £247, this is a saving of £53,105 (215 calls x £247) for the Ambulance Service in September alone (and this ignores the further NHS costs if any of these clients had been admitted to hospital).

iii) Please indicate the total amount from the BCF that has been allocated for the protection of adult social care services. (And please confirm that at least your local proportion of the £135m has been identified from the additional £1.9bn funding from the NHS in 2015/16 for the implementation of the new Care Act duties.)

The £10.5m existing funds, transferred under Section 256 from the NHS to adult social care in 2014/15, will continue in 2015/16. An additional transfer of £8m for the protection and continuity of adult social care services will be made in 2015/16, alongside a further transfer of £1.35 m for implementation of Care Act responsibilities, in line with national and local calculations.

iv) Please explain how the new duties resulting from care and support reform set out in the Care Act 2014 will be met

Oxfordshire County Council has a well-established major change programme in place - the Adult Services Improvement Programme - to oversee the transformation of adult social care and implementation of reforms resulting from the Care Act. The programme includes a range of projects and developments specifically targeted at meeting the demands of the reforms, including:

- Improving provision of online, telephone and face to face information and advice, including for self-funders
- Developing a model of self-assessments, and development of an e-marketplace to drive choice and control for individuals
- further support for carers in line with their right to access services, building on existing services including carers breaks
- improving existing processes and systems to avoid duplication and make them as effective as possible, including a new IT system for Adult Social Care
- developing new ways of working that support integration, including devolving responsibility to locality teams
- developing the local market to better meet the needs of individuals
- ensuring the social care workforce is suitably trained, skilled and rewarded

The Better Care Fund plan will help to fund a number of the above areas of work, either directly (in the case of improved IT systems and support for carers) or indirectly through releasing resources by meeting the costs of demographic pressures.

v) Please specify the level of resource that will be dedicated to carer-specific support

Oxfordshire has a long history of working with carers, which has been highlighted in national work. The County Council and the Clinical Commissioning Group currently spend in excess of £6 million on supporting carers, as part of the existing pooled budgets. Following modernisation of services in 2012, the number of carers known to services has increased by 14% since April 2013.

In addition, there are significant concerns locally and nationally that central government

calculations significantly underestimate the number of carers who may come forward for an assessment and who are eligible for services. We therefore anticipate that nearly all the resources for the Care Act (£1.35 million) will be spent on either assessing more carers or providing services to them following assessment.

vi) Please explain to what extent has the local authority's budget been affected against what was originally forecast with the original BCF plan?

There has been no impact on the budget as the allocation to protect social care is the same as in the original plan.

b) 7 day services to support discharge

Please describe your agreed local plans for implementing seven day services in health and social care to support patients being discharged and to 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 Multi-Disciplinary Units). We have also provided financial incentives to social care providers to pick up clients within 72 hours, including Fridays and over the weekend in both domiciliary care and care homes. The out of hours Social Care Emergency Duty Teams also ensure there is support available 24 hours a day, 7 days a week when needed.

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 co-ordination. By end of September 2015 we will have seven day a week, 8am to 8pm access to health locality teams (coterminous with OCCG localities). This will include a 2 hour response time to delivery of care for referrals for people with urgent and escalating needs. Referrals will be taken for: Reablement, Older People, Mental Health, including psychological therapies, Occupational Therapy, physiotherapy, Speech and Language therapy, dietetics and nutrition, podiatry, continence, and falls.

c) Data sharing

i) Please set out the plans you have in place for using the NHS Number as the primary identifier for correspondence across all health and care services.

Oxfordshire County Council is working with Oxford Health to ensure we are able to use the NHS number as the primary identifier for health and care services, and this will be built into routine processes in due course. NHS matching rates continue to improve although there is still some further work to achieve 100%.

ii) Please explain your approach for adopting systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK)).

Social Care and health colleagues are working together to ensure that our respective tender processes for the SWIFT (Adult Social Care) and RIO (Health) replacements are aligned. Integration requirements have been appropriately specified within both Statements of Requirements Procurement exercises across local NHS and OCC are now complete and effective integration arrangements are being developed with respective suppliers.

iii) Please explain your approach for ensuring that the appropriate Information Governance Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, professional clinical practice and in particular requirements set out in Caldicott 2.

Appropriate Information Governance controls are 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 for high risk populations

i) Please specify what proportion of the adult population are identified as at high risk of hospital admission, and what approach to risk stratification was used to identify them.

This is covered in more detail in Section 3, Case for Change.

ii) Please describe the joint process in place to assess risk, plan care and allocate a lead professional for this population

GPs will continue to have a central role in leading the care co-ordination and signposting of our most frail and vulnerable residents. We are committed to supporting the role of GPs through our integrated neighbourhood teams, to provide an increasing range of preventive and anticipatory measures to better support people closer to home and to avoid unnecessary non-elective admissions. Shared care co-ordination 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. The local health system has started on this work and each partner organisation has made progress with implementing national programmes. For example, community health

services are implementing multi-disciplinary integrated teams at locality level, social care is moving forward with improvements to services to meet the Care Act including supported self-assessment, and primary care is seizing the challenge of the Local Incentive Scheme which targets those 2% of patients at greatest risk of admission and offers support in the form of a care co-ordinator and care plan.

We want to take steps to foster a working approach of building trust across all professionals and partners. We seek to create an environment sufficient to merge social and medical cultures and move into integrated, more productive working relationships. We are developing the innovative approach of a 'Trusted Assessor' model, whereby professionals accept each other's assessments. This is currently being trialled within social care, as part of implementation of the Care Act. We intend to be a national leader in extending this initiative by means of enabling patients and carers to undertake their own self assessments and draw down their own individual budgets.

Oxfordshire County Council is 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 pilot work focuses on the development of a small and focused multi-disciplinary team of health and social care professionals within each locality who are able to respond and make decisions on urgent cases. Instead of clients in need of care or treatment having to contact several different agencies, these teams will assess each client's needs and deliver appropriate and responsive solutions tailored to that individual. As a basis for building integration and testing our pilot programme, our intention is to use the patient cohorts who frequently rely on emergency services, such as our high intensity users and the 2% of the registered populations that general practices have identified at high risk of admission.

iii) Please state what proportion of individuals at high risk already have a joint care plan in place

It is anticipated that upwards of 85% of individuals identified at high risk of hospital admission by both health and social care services will have a joint care plan in place. These numbers will include patients with Advance Care Plans in place, and numbers will fluctuate over time due to mortality and other factors.

8) ENGAGEMENT

a) Patient, service user and public engagement

Please describe how patients, service users and the public have been involved in the development of this plan to date and will be involved in the future.

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.

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 has been held with representatives of older people, learning and physical disability, mental health and carers to discuss and develop proposals.

This plan also aligns closely to the Oxfordshire Clinical Commissioning Group 5 Year Strategic Plan, that was subject to public consultation in late 2013 as part of the Call to Action. This plan has been further updated and refined in consultation with patient participation forums, patients and carers.

b) Service provider engagement

Please describe how the following groups of providers have been engaged in the development of the plan and the extent to which it is aligned with their operational plans

i) NHS Foundation Trusts and NHS Trusts

Apart from our system leadership arrangements, there have been extensive discussions at Chief Executive and Director level between the four organisations (OCCG, County Council, OUH, OUHT) as part of our shared commitment to tackle the issues and deliver the schemes set out in this plan. This has included a chief operating officer working group that met several times to develop the plan over the summer and autumn, full engagement in discussions at the Health and Wellbeing Board meetings in March, September and January, and direct involvement in developing implementation plans.

The schemes are closely aligned to the operational plans of both Oxford University Hospitals Trust and Oxford Health NHS Foundation Trust, There is also a strong alignment with ongoing negotiations to develop an outcomes based commissioning model for frail older people, for which the providers have contributed a detailed proposal.

All four organisations have also publically committed to the development of a single Health and Social Care Strategy for Oxfordshire over the coming months.

Given the scale of the challenge to deliver a 6.5% saving on non-elective admissions (2013/14 baseline) (2% reduction + 4.5% growth), all parties have agreed to jointly manage the risks associated with this level of transformation and change. Going forward all parties have agreed that we will work together to further refine our plans, to ensure that all are able to validate assumed activity reductions, which can then be considered as part of the annual contracting round 2015/16. We note also the ongoing OCCG assessment of the OUH and OHFT joint venture as 'most capable' provider for delivery of the Older People's Strategy. In the event that the joint venture is deemed successful, the OCCG will amend the BCF plan to better reflect this.

In addition all of our schemes have benefited from strong clinical leadership, having been

developed by clinicians and professionals coming together through working groups and workshops, on areas such as the DToC plan and ambulatory care pathways.

Please note that CCGs are asked to share their non-elective admissions planned figures (general and acute only) from two operational year plans with local acute providers. Each local acute provider is then asked to complete a template providing their commentary – see Annex 2 – Provider Commentary.

ii) primary care providers

The six localities across the CCG have been briefed during the development of the BCF plans, and a number of localities are involved in piloting aspects of the plan's delivery. Primary care has been represented in the discussions amongst Chief Executives.

OCCG sees primary care as a key element of the front-line services that patients can access to receive direct care, information or advice. The role of general practice as a gate-keeper and onward referrer to other services needs to be enhanced in order to avoid its gatekeeping function becoming swamped, and access to secondary care services becoming the default choice for patients. OCCG and its member practices are developing a Primary Care Strategy, consistent with the national principles articulated in the NHSE Five Year Forward View – particularly to strengthen its front-line role and to enhance an intermediate level of service provided via 'intermediate' care hubs and collaborative models of care between practices.

Increased capacity in primary care – via new roles such as Physicians' Assistants and Emergency Care Practitioners, as well as multi-disciplinary access to pharmacists, specialist nurses responsible for a group of patients with a range of long-term conditions, and nurse practitioners responsible for minor illness or injury – will run alongside transformational approaches to complex case management, outcomes based commissioning, and devolution of budgets and multi-disciplinary staff to tackle locality issues through groupings of practices (potentially as a type of Integrated Care Organisation).

iii) social care and providers from the voluntary and community sector

Adult Social Care has been a key partner in the development of this plan, and has played a full and active role in working groups and engagement with providers from across health and social care.

Providers of social care have been engaged in the development of the Older People's commissioning strategy and the Joint Health and Wellbeing Strategy, and participated in a workshop in early 2014 to inform the development of the plan along with representatives of older people, learning and physical disability, mental health and carers to discuss and develop proposals.

The County Council helped establish the Oxfordshire Association of Care Providers in 2014. This has enabled adult social care providers to be involved in discussions about the response to key operational issues such as the resolving blockages in the system that lead to delayed transfers of care.

c) Implications for acute providers

Please clearly quantify the impact on NHS acute service delivery targets. The details of this response must be developed with the relevant NHS providers, and include:

- **What is the impact of the proposed BCF schemes on activity, income and spending for local acute providers?**
- **Are local providers' plans for 2015/16 consistent with the BCF plan set out here?**

The challenge to reduce emergency admissions and to improve DToC is clear, and understood by all partners. As a health and social care community we share joint and equal responsibility for performance across the system and have agreed the rationale for setting a 2% reduction target in respect of non-elective admissions (set out in 'Case for Change' section 3), and duly developed our plans to achieve this target. That said our collective ambitions extend beyond this and with the full support of OUH, through SRG we will build on this to increase our target to 3.5% over the coming year.

We recognise that if our schemes fail to deliver the anticipated benefits for the 95% A&E target, non-elective admissions and DToC, the impact of the failure will be keenly felt by our acute care colleagues both clinically and financially. We believe we have robust governance in place to monitor performance and manage risks as a whole-system, within our SRG and system leadership mechanisms.

Translated into the number of non-elective admissions saved, against the 2013/14 base-line we expect to achieve a reduction of 3,400 in 2015/16. This reduction in activity will release just over £5m back into the commissioning pot.

With regard to delayed transfers of care, against the 2013/14 baseline, our plans aim to save 3,364 bed days delayed in an acute setting. This should result in savings related to excess bed days in the region of £1.7m to the commissioner and providers. We would expect to see a reduction in DToC numbers (averaging 151 year to date) achieving a target of below 100 by year end (2015/16).

The above initiatives should incentivise our acute partner to reduce bed-based infrastructure and in doing so, OUH should also experience cost savings. OUH is yet to quantify and share the opportunity this presents with the rest of the health/social care community.

Our plans to improve primary care escalation out of hours have been calculated to save around 11,200 presentations in A&E, which should release £722k back to commissioners and support our plans to achieve 95% A&E target.

Detailed work remains to finalise the specific means by which the desired distribution of funds, and associated management of risk, will be achieved across the health and social care economy. Part of this work is inevitably linked to the finalisation of OCCG commissioning intentions and 2015/16 contracting with all NHS Providers.

ANNEX 1 – Detailed Scheme Description

For more detail on how to complete this template, please refer to the Technical Guidance

Scheme ref no. 1

Scheme name:– Emergency Multi-Disciplinary Unit (EMU)

What is the strategic objective of this scheme?

Expansion of an existing scheme.
The Emergency Multi-Disciplinary Unit (EMU) is a key component of the 'Healthier in Oxfordshire' (blueprint) for priority in the Older People's Joint Commissioning Strategy 2013-16. The scheme offers a tangible and more appropriate alternative to A&E for those who are frail and vulnerable to acute admission. Patients may access the service in response to acute illness or because they require a multi-disciplinary assessment to prevent further deterioration of their condition.

Overview of the scheme

EMUs are Multi-Disciplinary Team (MDT) assessment units which include medical, nursing, therapy and social care to:

- Assess urgent sub-acute health & social care needs to avoid an acute admission
- Provision of sub-acute 'turnaround' 72 hour beds
- Facilitate discharge from acute admission through community MDT assessment of reablement / rehabilitation / medical / nursing / social care needs
- Interface with locality provision to agree and implement intervention / treatment within four hours of assessment (admission avoidance and early supported discharge)
- Provision of outpatient rehabilitation therapy
- Follow-up and review
- Discharge to GP / onward referral as appropriate

Facilitate and support effective communication of patient needs, diagnosis and treatment to relevant service providers contributing to individual's care.

The proposal is to expand the existing EMU services in Abingdon and Witney, to two more sites in Banbury (Horton Hospital) and Oxford City (The John Radcliffe Hospital). In addition system partners are designing a 'virtual' EMU which will provide county-wide coverage, and rely on technological solutions, such as point of care testing, telemedicine and remote working technology, to enable frontline community healthcare professionals to access specialist medical, gerontology, diagnostics and advice, so that people can be cared for in their own homes.

The delivery chain

Commissioners are Oxfordshire CCG and Oxfordshire County Council.
The current provider is OHFT.

The evidence base

The two existing EMUs in Oxfordshire have a proven track record of providing an alternative to A&E. The EMUs have received positive reviews from ECIST during a recent whole system diagnostic and are viewed as an essential service by GPs.

Investment requirements

Based on our experience with existing EMU services, we anticipate each new EMU to require revenue costs of £1m/annum. Essentially this will be derived from savings as a result of reducing dispositions to the emergency departments and non-elective admissions. Any capital set up costs will be borne by the provider for these services and factored into their internal proposition for running the services. The costs of the virtual EMU are under development.
Impact of scheme
The key system benefits from EMUs are: a) Reduction in A&E attendances. b) Reduction in admissions. c) Reduction in outpatient appointments. d) Increased early supported discharge leading to reduction in length of stay.
Feedback loop
The development of the new EMUs will be monitored through the SRG. The anticipated benefits including performance against non-elective admission and A&E attendance will be monitored through KPIs as part of the SRG dashboard. Once developed the schemes will be included in the established contract monitoring cycle.
What are the key success factors for implementation of this scheme?
• Impact on improving performance against 95% A&E target. • Reduction in non-elective admissions in line with BCF plan. • Delivery of a service focused on admission avoidance and early discharge through the provision of urgent sub-acute medical and social care. • ‘Buy-in’ to service from GPs and acute service provided to ensure that sufficient suitable referrals are received. • High patient satisfaction with the service.

Scheme ref no. 2
Scheme name:– Reablement pathway
What is the strategic objective of this scheme?
Expansion of an existing scheme. This is focused on increasing the number of people who could recieve reablement in the community. The system outcome is to reduce the long-term care needs of individuals. Development of a more sustainable system which will reduce costs and enhance the quality of medical and social care received by patients. The focus of this scheme is to reappraise the multiple reablement services and existing pathways and seek to have one consistent pathway, assessment and process established.
Overview of the scheme
• The focus is on increasing the amount of reablement activity that occurs prior to admission, thus reducing system demand and improving the delivery of community based reablement support. Using established outcome-based models for home care alongside the national model for reablement, we will move to a single managed and coordinated pathway. • OCC will commission a single reablement pathway that will increase reablement activity by 50%, whilst ensuring reablement delivery is integrated into home care provision on an outcomes basis. • The new service to be focused on Increasing the quality and coordination of care given to patients. • It is proposed that there will be a reduction of costs though removal of management overheads, duplication and inefficiencies through multiple hands overs and referrals.
The delivery chain
The service is jointly commissioned between OOCG and OCC. The current main providers are OHFT (Reablement Service), OUH (Supported Hospital Discharge Service), and a range of third sector and private home care providers (reablement elements in home care provision, Discharge to Assess (D2A), and enhanced home care provision).
The evidence base
1. Evidence suggest that the current establishment of reablement services is overly complex and contains duplication. 2. Increasing the patient numbers through reablement should improve the independence of individuals and prevent premature need for domiciliary and/or care home provision.
Investment requirements
OCC currently spend £5.5m and OCCG currently spend £1.5m on reablement. We intend to increase the overall spend on services that reable over the next 3 years – primarily by delivering increased reablement outcomes in home cares. Assumptions on reablement spend are £5m from the older peoples pool on the reablement service (£3.5m from OCC and £1.5m from OCCG), £1.5m on SHDS outside the pool from

OCCG, and currently 10% of home care delivery (£20m from OCC in the Older Peoples Pool) delivering reablement outcomes. Investment will be required in the project management of the review and design of the new service and the re-procurement of services
Impact of scheme
An effective reablement pathway will result in: c) Reduction in patients ongoing care needs d) Cost savings to the system e) Improved patient experience f) Reduction in DToC
Feedback loop
The development of reablement will be monitored through the SRG. The anticipated benefits including performance against DToC will be monitored through KPIs as part of the SRG dashboard. Once developed the schemes will be included in the established contract monitoring cycle.
What are the key success factors for implementation of this scheme?
a) Reduction in DToC where reablement is the main reason for the delay. b) Reduction in proportion of older people requiring domiciliary/care home support. c) Streamlined reablement service – reducing handoffs. d) High patient satisfaction with the service.

Scheme ref no. 3
Scheme name:– Reducing Delayed Transfers of Care
What is the strategic objective of this scheme?
New scheme. The Oxfordshire Delayed Transfers of Care (DToC) plan sets out the priority goals, objectives and actions that will be enacted in 2015/16 and beyond to improve performance against DToC key performance indicators. In essence the whole-system in Oxfordshire is working in partnership to reduce the proportion of individuals delayed unnecessarily in an acute environment.
Overview of the scheme
DToC Goals: The DToC goals are aligned to each of the main reasons for delayed transfers of care and provide a framework for improving clinical practice and process management and form the structure of the DtoC Plan. **Goal 1. Choice:** To support patients and their families with exercising choice when care transfers, by managing expectations and ensuring that all processes are effectively managed to prevent unacceptable, extended inpatient care. **Goal 2. Reablement:** To increase the numbers of individuals who could benefit from reablement services, thus improving their confidence and capability with regards to self-care management within their home, and reducing the likelihood of premature dependency on long term care interventions. **Goal 3. Assessment:** To ensure individuals access person-centred, comprehensive, appropriate and timely assessments, which foster the early engagement of their families/carers (where appropriate), and lead to a smooth transfer of care between agencies, thus preventing unnecessary delays. **Goal 4. Non-acute NHS beds:** To enable medically stable patients who require access to inpatient rehabilitation, gain an optimal level of functioning following a period of illness including stroke, trauma and other medical conditions. **Goal 5. Long Term Care Package:** To enable people with reduced functionality to remain in their home, thus promoting and prolonging individual self-care and reducing the likelihood of premature dependency on institutionalised care. **Goal 6. Residential Care and Nursing Homes:** To ensure that individuals who require residential care, have timely access to facilities that promote individual self-determination and are responsive to the changing physical and psychological needs of the individual. . **Goal 7. Housing:** To identify and remedy an individual's housing needs at the earliest opportunity, thus preventing deterioration and need for health/social care intervention and/or delays in discharge from healthcare. **Scheme Priorities:** The process of investigation into DToC has identified 4 critical success factors that have been built into the plan: • Earlier engagement of patients and their families in transfer of care options,

- Improve the timeliness and efficiency of the assessment pathway particularly for frail, older people (including continuing health care assessments).
- Become less 'risk averse' as a health/social care system thereby increasing the proportion of patients considered suitable for reablement.
- Develop a broader perspective of what constitutes the whole-system thus bringing the independent care and residential provider sector alongside statutory agencies.

Primary Objectives: In addition the plan has identified 6 primary objectives that are anticipated to have a significant impact on improving DToC performance:

1. Full implementation of the joint Choice Policy.
2. To bring about an increase the proportion of people who access reablement by default including a rise in uptake direct from the community.
3. The development of an acute/community single assessment process for frail older people, with single documentation and consistent clinical assessment standards which are accepted by the onward step of the pathway.
4. Taking steps to improve market management of independent care and residential agencies, and ensuring the risks and pressures that face this industry are understood as part of the whole system in Oxfordshire.
5. The development of a homeless discharge pathway working with key homeless charities in Oxfordshire.
6. The development of a housing assessment pathway to ensure that an individual's housing needs are considered as early as possible, preferable before deterioration and an emergency admission are inevitable.

The delivery chain

Commissioners are OCCG and OCC.

The main providers are OHFT, OUH and Oxfordshire adult social care.

Other contributors include Age UK Oxfordshire, care homes, home care providers and other third sector providers who currently hold contracts to deliver services in Oxfordshire.

The evidence base

All statutory agencies are jointly responsible for delayed transfers of care that have been an enduring feature of the health and social care landscape in Oxfordshire. Nationally Oxfordshire has been an outlier since April 2011 when the Department of Health first started to publish the number of people delayed in inpatient care. At 27.2 per 100,000 population, Oxfordshire is almost 3 times the England average 9.7 per 100,000. (DH 13/14 average). Over the last year the system has seen some moderate improvement in delays where social care has been identified as the main reason, however overall this has not been sufficient to meet a 4.7% annual growth in demand within the emergency departments in Oxfordshire University Hospitals NHS Trust (OUH), in part attributable to an1% increase in the population aged 60 and above (in comparison with last year).

A whole system investigation led by the Oxfordshire CCG and involving all agencies,

has identified a range of issues which contribute to DtoC as specified in the Oxfordshire DToC Plan.

Investment requirements

The plan includes both transactional and transformational objectives for improvement. Management of the plan sits with a multi-agency steering group that is operational in format, reporting into the Systems Resilience Group. This means that additional investment in project management is not required at this time.

Initially the plan is about improving the operational process of managing those who are avoidably delayed in their care which does not require further investment. However a number of areas for improvement may require investment at a future date which is yet to be determined. The primary reasons for DtoC are broad and the suite of initiatives contained within the Better Care Fund (BCF) plan are highly likely to have an impact on DtoC. Hence although there will be some overlaying of schemes between the DtoC Plan and the BCF Plan, the investment requirements will be made explicit in the BCF Plan, so as to avoid double counting in respect of improvement metrics and investment.

Impact of scheme

System Wide Benefits – when fully implemented

i Reduced delayed transfers of care.
ii Earlier engagement of patients and their families/carers in ongoing care options.
iii Improved assessment pathway for frail older people.
iv Improved understanding of the financial, operational, workforce and other levers/constraints that impact on the independent care agency and residential care sector, and therein improved market management of the same.
v Improved acute sector management of the continuing care assessment pathway.
vi Increased use of reablement services.
vii Earlier identification, and improvement in the management of individuals with housing issues, including those who are homeless and those whose housing requires deep-cleaning, maintenance or adaptations.
viii Improved patient flow through the acute hospital system.
ix Contributes to reducing the risk of crowding in the emergency department.
x Financial benefit arising from reduced length of stay – potential for reducing acute bed base.

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

Feedback loop

A small steering group drawn from the leads for each of the DToC goals will report progress against the plan to the SRG quarterly and by exception should any extraordinary issue arise. A number of new key performance indicators (KPIs) are indicated in the plan and these will be incorporated into the SRG dashboard.

What are the key success factors for implementation of this scheme?

- A reduction in DtoC against each of the main reasons for delay.
- Joint Choice Policy fully implemented.
- Earlier engagement of patients and their familes/carers in ongoing care

options.

- Earlier involvement of social care where appropriate and the enactment of section 2s and 5s.
- Improved relationships with the independent sector and effective market management.

Scheme ref no. 4

Scheme name:– Ambulatory Emergency Care (AEC)

What is the strategic objective of this scheme?

New scheme.
The Kings Fund reported in 2013 that commissioners should shift the current emphasis on acute and episodic care towards prevention, self-care and integrated & well-co-ordinated care to cope with an ageing population and increased prevalence of chronic diseases. Changes arising from advances in medical and surgical care, an increasingly skilled workforce, diagnostics and multidisciplinary working support service redesign opportunities in Oxfordshire. The AEC proposal presents an excellent opportunity to transform how traditional services are re-designed and delivered.

Overview of the scheme

AEC is defined by the Royal College of Physicians as:
"Ambulatory (emergency) care is clinical care which may include diagnosis, observation, treatment and rehabilitation, not provided within the traditional hospital bed base or outpatient services and can be provided across the primary / secondary interface" (Royal College of Physicians 2007)

AEC Pathways are intended to manage patients presenting at an acute setting who require treatment, without requiring admission. Patients are managed in a specific area with full access to diagnostics, medical advice and care with the intention that they will be appropriately discharged into the community as soon as possible.

Best Practice Tariff (BPT) has been introduced to 19 of the scenarios to promote ambulatory care management for patients who are currently admitted and stay overnight. The 19 scenarios have been selected from the 'NHS Institute's Directory of AEC in Adults'. The aim is to encourage the management of specific conditions within the same day.

To achieve a functioning AEC model it is essential that a senior clinical review model is adopted so that patient management plans can be initiated immediately. The AEC model creates a 'virtual ward' of patients under remote clinical supervision whilst at home. The avoidance of unnecessary overnight stays for emergency patients not only improves the quality of patient care and experience but also reduces occupied bed days in hospital.
Technological developments mean that patients are increasingly benefitting from shorter lengths of stay. The result is that fewer in-patient beds are needed and ambulatory type facilities are becoming more suitable, increasing the pathway of choice for patient care and treatment so patients are seen promptly, in the right place, by the right person and at the right time.

Each of the conditions identified in the Directory of Ambulatory Emergency Care for Adults have a lower & upper limit as guidance for modelling activity levels. For the purpose of this business case the upper limits have been used to calculate the proposed activity levels for each condition (listed in table 1 below) for patients being admitted to OUHT for the period October 2012 – September 2013 inclusive.

62 HRGs have been identified across 24 ambulatory conditions.
Analysis has identified that there were 11,105 emergency admissions relating to these ambulatory conditions in the period October 2012-September 2013. The Directory of Ambulatory Emergency Care for adults produced by the NHS Institute identifies the range of potential percentages of admissions suitable for ambulatory care. The proposed changes of implementing an AEC model would offer the ability to increase this and achieve the upper limit.

The home care services commissioned by OCC will support appropriate discharge into the community in a timely way. Existing packages of care will support people once they have been through the AEC Pathways. The future outcomes based approach to home care will enable people to manage in their own home and will support people to regain their independence.

Using a new equipment contract OCC will be able to install telecare equipment, as appropriate, so that individuals can be monitored in their own homes. The telecare equipment will be linked to a call centre so that individuals can be monitored and action taken in an emergency. Furthermore OCC's workforce development programme is training social care and health practitioners on the use of telecare equipment and its installation.

The delivery chain

Commissioners are OCCG

The main providers are OHFT and OUH.

The evidence base

AEC Pathways have been successfully implemented in many health systems. Evidence has shown that where the AEC model has been implemented there has been immediate impact in the following 6 key areas:

- Patient experience
- Safety
- Timeliness
- Efficiency
- Effectiveness
- Patient-centred Care

The underlying principle of AEC is that a significant proportion of emergency adult inpatients can be managed safely and appropriately on the same day without resulting in hospital admission. The Directory of ambulatory emergency care for adults identifies 49 clinical scenarios that could be managed on an ambulatory basis.

Investment requirements

No further investment is required at this stage. The implementation of new pathways should reduce costs for the commissioner arising from the transfer of payment for care under ambulatory best-practice tariffs for zero day length of stay and/or reduced short-stay tariffs.

Impact of scheme

An AEC model will provide rapid senior review, rapid diagnostics and rapid turnaround for patients without the requirement of staying overnight in a hospital bed. This will provide a positive impact on patient quality of care.

Feedback loop

The development of AEC pathways will be monitored through the SRG. The anticipated benefits including performance against non-elective admissions will be

monitored through KPIs as part of the SRG dashboard. Once developed the schemes will be included in the established contract monitoring cycle. HRG codes identified will be monitored to map the increase in same day treatment reducing Length of Stay to 0 days.
What are the key success factors for implementation of this scheme?
e) Reduction in the number of avoidable A&E attendances and non-elective admissions f) Patients receiving care closer to home.

Scheme ref no. 5
Scheme name – Integrated Neighbourhood Teams
What is the strategic objective of this scheme?
New scheme. This scheme will bring professionals together to deliver joined up personalised integrated care to patients in the community. The system outcomes are: improved population health; efficiency and effectiveness gains; and reduced service use through improved health and social capacity. This will bring integrated neighbourhood teams across primary care, social care and community health; working to a county model, with a single point of access, locality hubs and delivered across communities. Delivering the full range of support and care to the adult physical health and older people mental health requirements out of hospital. Working in partnership with volunteer organisations and private care providers.
Overview of the scheme
Model of care – neighbourhood teams will be based around an adult GP population of 30,000 – 50,000, delivering integrated health and social care. Supported by joint back office 'hubs' based at a locality level and a countywide single point of access. - Working in partnership with volunteer organisations - Delivering a person centred approach - With a joined up electronic record, single assessments, care plans and personal support plans Patient cohort – covers the adult population of Oxfordshire, however those who will benefit the most are the older population and adults with complex needs.
The delivery chain
Commissioners are OCCG and OCC. The main providers will be OHFT, Oxfordshire adult social care and Oxfordshire GPs. Other providers include Age UK Oxfordshire, care homes, home care providers and other third sector providers who currently hold contracts to deliver services in Oxfordshire.
The evidence base
The evidence base is extensive, and the programme has drawn on both recent and historical published reports on the successful delivery of Integrated Care both nationally and internationally. It has also drawn on both the national and local involvement with the public, on what they want and need to remain independent and well in their own communities. This has been enhanced from the learning of being a Personal Health Budget site, with

successful delivery to over 120 users and the work to implement integrated health and social care budgets.

The learning from the impact of PHB in Oxfordshire, by improving quality of life, reducing reliance on health care and reduction of package costs, is being taken into account

The learning from the lean programme in social care on the delivery of social care, and from the review of Personal Budgets delivery in social cared.

The additional evidence base and impact is from the Oxfordshire Whole System analysis on the current state, issues, gaps and the individual pathways. Showing up the shortcomings of the current models, that have led to an over complicated system in the community that has led to duplication and sub-optimal outcomes for both the users of the system and the staff who work within it in some key areas.

Investment requirements

Programme Director to lead and co-ordinate the work on behalf of OCC, OCCG Group and OHFT.

Impact of scheme

System Wide Benefits – when fully implemented

i Efficiency Gains

- Reduction in GP appointments used just to refer to other professionals.
- Reduce GP appointments by improvements in planned care by 243 per day (3 per practice per day).
- Reduce GP home visits by 81 per week by alternative response (1 per practice per week).
- Less handoffs between teams and professionals.
- More end of life care delivered at home.
- Reduce duplication, so reduce one duplicate visit per team per day (75 per week).
- Individual takes up responsibility for managing their own care from personal agreed outcomes.

ii Effectiveness Savings

- By less health crisis, leading to input from health and or social care teams.
- Reduced Hospital admissions (15 per week).
- Reduced Ambulance call outs (45 per week).
- Reduced Emergency Department visits (45 per week).
- Reduced care home admissions (180 per year) / shorter stays in care homes.
- Earlier planned discharge from hospital (15 per week).

iii Improved Population Health

- Improved self-management of Long Terms Conditions and complex health and social care.
- Improve the independence and decrease loneliness and depression of the older population and adults complex needs.

v Improved use of resources

- Joined up IT, leading to shared / single records.
- Improved use of estates across whole system.
- Reduce the burden on front line staff by streamlining, and improving accountability.

v Safer health and social care

- Joined up IT leading to shared records.
- Joined up teams.
- One patient assessment and one care record.
- Access to right support at first visit.

i Individuals

- Empowered to live the life they want to within whatever physical or conative limitations they have .
- Personalised care integrated around them with agreed person outcomes, so listened to what will make the difference to them, so deliver the right fit to the individual.
- Improved information and support to and for individuals and their support system, so they are empowered to make informed choices.
- Have only to tell their information once; one integrated assessment and care plan that works for them not around services.
- Supported in place to stay independent and active at home.
- Supported to die at home if that is what they want.
- Supported to stay out of hospital, except for planned care best delivered there.

Feedback loop

The Integrated Community Localities Programme Board oversees this work, and meets monthly, the Programme Director reports on the milestone plan and on the outputs from the agreed working groups developing and implementing the model.

This Board reports to the System Transformational Group which in turn reports to the System Leadership and the Health and Wellbeing Board.

When the countywide community health and social care teams are up and running in 2015, the KPIs will be reported.

What are the key success factors for implementation of this scheme?

- To have delivered a new model of care for the delivery of community integration, and implemented it in 2015.
- To have a single point of access for professionals to health and social care in the community in place
- To have a Financial Flows Plan to support integrated delivery.
- To have a rolling training programme to change of culture across all sectors to a personalised enabling approach.

- To have a county plan for electronic integrated patient notes.
- That the public and patients / users are leaders in the integration developments.
- That key voluntary organisations are partners in integration design and delivery.
- To have system leadership in the community that enhances an integrated approach.
- To have a joined up IT plan.

Scheme ref no. 6
Scheme name – Care Closer to Home (Advance care plans/end of life care and proactive medical support to care homes)
What is the strategic objective of this scheme?
New scheme. This scheme is about ensuring that our most frail citizens have access to appropriate care closer to home, in way that prevents unnecessary admission and improves the quality of End of Life Care. The scheme pulls together a focus on our top 2% most at risk of a non-elective admission. This scheme is not just patients in care homes, although a significant proportion of frail, elderly citizens are resident in care and nursing homes. A more sustainable system which will reduce costs and improve quality of life for patients and enhance the quality of medical cover for all residents of care and nursing homes, resulting in a reduction of the number of Non Elective (NEL) emergency admissions through proactive planning.
Overview of the scheme
There are two main components to this scheme **Advanced Care Plans** - 1) Building up from the requirements of the GMS contract, GPs will be required to identify their highest 2% risk patients and case manage them to avoid unplanned admissions. 2) Implementation of a risk prediction tool to identify patients at high risk of admission to hospital which will inform a treatment plan and reduce the volume of avoidable admissions. **Proactive Medical Support to Care / Nursing Homes** • Facilitating the shift from 'active' management of disease with the aim of prolonging life, towards care with the primary aim of keeping the patient comfortable (often keeping them in the nursing home and avoiding unnecessary admission). • Rationalising the delivery of care by aligning every care home with a named practice and GP. • Delivering pro-active health care based on regular visits and contacts with Care and Nursing Homes to reduce crisis management and any further functional deterioration. • Removing multiple consultations per visit and providing a nor co-ordinated management of long term conditions.
The delivery chain
Commissioners are OCCG The main providers are GP practices and community providers.
The evidence base
National evidence suggests that enhanced primary care medical services to care / nursing homes has had success in driving up the quality of care and reducing

admissions / attendances to hospital and length of stay for patients where admittance to hospital is unavoidable. In nursing homes where there is no arrangement for a GP practice to provide weekly, routine visits and reviews, care is often reactive.

Anticipated outcomes for service users echo those of the British Geriatric Society Commissioning Guidance 2013:
'Improved experience through high quality essential care and less disruption and stress caused to elderly patients by the reduction in the number of inappropriate secondary care attendances and admissions to hospital – delivered through the enhanced primary care service and supported by a comprehensive range of support services'

Three examples of where the model has been successful are as follows:

3. In year one a pilot conducted in Yorkshire and Humber NHS, there was a reduction in emergency admissions of 6 admissions per 100 care home beds (approximately 9%) compared with the year before. In addition, the number of A&E attendances fell by 3 attendances per 100 care home beds (approximately 10%) compared to the year before.
4. Bath and North Somerset CCG has an enhanced service in place which sees GPs making regular ward round visits to nursing homes. This service now in the second year of a trial period, has seen the number of nursing home residents (registered with a BaNES GP) admitted to the RUH in Bath decrease by 40% since April 2012
5. In East Cheshire, the introduction of one dedicated GP session per week via a contracted Local Enhanced Service to a Nursing Home has shown a statistically significant reduction in admissions to hospital. The study (reported this year) concluded that if this trend can be replicated on a larger scale residents should benefit from having consistent care and avoid potentially distressing hospital stays. Additionally, fiscal and resource benefits should be seen.

Investment requirements

Payment to practices is likely to be on a per bed per year basis within a range of £150 - £200, subject to the business case being agreed and negotiation with the LMC.

Impact of scheme

Proactive care planning will reduce the pressure on the following areas of the system:

1) 999 Emergency Calls.
2) 111 Calls.
3) Out of Hours (OOH) requests.
4) A&E attendance.
5) NEL admissions.
    a. 29% reduction in NEL admissions from residents of care / nursing homes (500 per annum).
    b. 5% reduction in NEL admissions of the highest 2% of patients on the register of most risk of emergency admission.

Feedback loop

The development of care closer to home will be monitored through the SRG. The anticipated benefits including performance against non-elective admissions will be monitored through KPIs as part of the SRG dashboard.

What are the key success factors for implementation of this scheme?
• Reduction in the number of avoidable A&E attendances and non-elective admissions. • Patients receiving care closer to home. • Facilitating the shift from ‘active’ management of disease with the aim of prolonging life, towards care with the primary aim of keeping the patients comfortable.

Scheme ref no. 7
Scheme name: – Hospital at Home
What is the strategic objective of this scheme?
Expansion of an existing scheme. This scheme is about expanding the provision of Hospital@Home, essentially delivering across the whole county 24/7, to maintain peoples care within their own home, through a sub-acute episode of need, for up to 14 days, including: • rapid community assessment and intervention to avoid acute admission, • nursing intervention to facilitate and enable timely discharge from acute admission, • holistic care that promotes and supports individuals in maintaining their independence. Integrated operational delivery across the sub-acute urgent care pathway to ensure high quality, safe care that minimises patient delays in all settings; working in partnership with out of hours services, crisis services and community nursing.
Overview of the scheme
The objectives for this service are to establish and deliver : • GP locality-specific operational pathways to deliver sub-acute urgent nursing care in the individual's home, seven days a week. • Assessment and intervention within 0-4 hours of referral. • Facilitate effective primary care (in and out of hours) assessment and review of patients to provide medical input to home-based urgent nursing care. • Co-ordination of multi-disciplinary assessment, intervention and review of patients referred into the service (in or close to their home.) • Effective joint operational delivery of urgent care in the home with social care rapid / "crisis" support. • Effective interface arrangements with acute (Emergency Department, Diagnostics and Gerontology / General Medicine specialist / inpatient provision), ambulance providers (999 and patient transport services) to ensure patients are treated in their own home wherever clinically appropriate, and supported in early and proactive discharge from acute inpatient admission. • Effective operational liaison with other community health and social care services (urgent and planned care, statutory and third sector provision – e.g. long term conditions management, end of life care, care home support service, reablement and long term care) to ensure coordinated and seamless patient care, and timely and safe discharge from Hospital at Home. Patient cohort – covers the adult population 18+ who are registered with an Oxfordshire CCG GP Delivering: • Assessment and monitoring of patient vital signs. • Holistic nursing care to support stabilisation / recovery of presenting condition, including ensuring mobility, nutrition, fluids. • Phlebotomy. • Anticoagulant stabilisation therapy.

- DVT treatment.
- Blood transfusions (to be determined).
- Subcutaneous fluids.
- IV antibiotics.
- Urgent provision of equipment.

The delivery chain

The commissioners are OCCG.

There are two providers split geographically - OHFT (South and East including Oxford City) PML (North and West).

The evidence base

A systematic review of trials comparing 'hospital at home' schemes with inpatient care found that, for selected patients, avoiding admission through provision of hospital care at home yielded similar outcomes to inpatient care, at a similar or lower cost (Shepperd *et al* 2009a). Elderly patients with a medical event such as stroke or COPD, who are clinically stable and do not require diagnostic or specialist input, had slightly more subsequent admissions in the hospital at home group, but had greater levels of satisfaction, and their care at home was less expensive.

The additional evidence base and impact is from the Oxfordshire Whole System analysis on the current state, issues, gaps and the individual pathways. Which is showing the effect of Hospital at Home delivered in the county on deflection of admissions; especially in the exacerbation of illness in the last few weeks of life.

Investment requirements

The cost of the service county wide is £1.4 Million.

Impact of scheme

Reduction of non-elective admissions annually of 1,835.

This has the additional effect of reducing ambulance call outs and emergency department attendances.

Reducing the length of stay following elective surgery.

Feedback loop

The development of hospital@home will be monitored through the SRG. The anticipated benefits including performance against DToC and reduced non-elective admissions will be monitored through KPIs as part of the SRG dashboard.

Once developed the schemes will be included in the established contract monitoring cycle.

What are the key success factors for implementation of this scheme?

Reduction of non-elective admissions for individuals who are experiencing:

- Reduction in non-elective admissions.
- Reduction in DToC for nonacute onward transfer of care to a community bed or service.
- Exacerbations of chronic diseases (including COPD, heart failure, diabetes, dementia).
- Reduction in sudden onset medical illness in frail elderly.
- Maintaining individuals with a range of infections at home.
- Increasing the number of people who are enabled to die at home with dignity.

- Reducing the length of stay following elective surgery by delivering the care / monitoring at home.

Scheme ref no. 8
Scheme name – Oxfordshire Care Summary: proactive care planning
What is the strategic objective of this scheme?
Existing scheme. Avoiding unplanned admissions through the capturing and sharing of electronic data to produce multi-agency, high-quality, up-to-date care plans at the point of care.
Overview of the scheme
The Oxfordshire Care Summary (OCS) already delivers standard views of data from GP practices and the Oxford University Hospitals Trust (OUHT) to over 800 registered clinical users, with demonstrable benefits. It is anticipated that this number will rise sharply in early 2015 The data set required for high-quality care planning has already been identified by clinical users in response to the enhanced service specification: risk profiling and care management scheme. The proactive care planning scheme will: • Enable the capturing of the care planning data set in GP systems by means of a clinical template. • Enable the sharing of the care planning data set to the Oxfordshire Care Summary by means of requesting the approved Read codes from the data supplier. • Enable the most effective presentation of the care planning data set by means of liaising with urgent care clinicians to develop the display within the Oxfordshire Care Summary • Promote the posting of care documents such as DNACPR forms for sharing via the OCS. • Promote the use of the Oxfordshire Care Summary across health and social care providers in Oxfordshire. • Seek clinical data from other providers as soon as it is available in order to increase the breadth and depth of the data set and to reduce the risk of processing errors in the information chain.
The delivery chain
• OCCG commissions the OCS. The Senior Responsible Officer for the project is the Chief Finance Officer, and the project is overseen by the CCG IM&T programme board. • The project board has clinical representation from OCCG, GPs, OHFT, OUH, and OCC. • Suppliers are OUH IM&T department (software and development), and Healthcare Gateway Ltd (GP data via the Medical Interoperability Gateway). • The project is run by the Central Southern Commissioning Support Unit.
The evidence base
1. In April 2014, NHS England stated: Unplanned admissions to hospital are distressing and disruptive for patients, carers and families. Many unplanned admissions are for patients who are elderly, infirm or have complex physical or mental health and care needs which put them at high risk of unplanned admission or re-admission to hospital (NHS England Gateway reference: 01520) 2. The OCCG five year strategy and implementation plan (2014) stated these

objectives to:

- Be financially sustainable.
- Be delivering fully integrated care, close to home, for the frail elderly and people with multiple physical and/or mental health needs.
- Routinely enable people to live well at home and to avoid admission to hospital when this is in their best interests

3. The NHS Commissioning Board enhanced service specification for risk profiling and care management scheme (2014) aimed to identify patients most at risk of serious illness or emergency hospital admission and instigate proactive care planning to improve their quality of care and life and to reduce avoidable admissions to hospital
4. In December 2014 informal reports indicate that urgent care services often still do not have access to care plans where they feel patients meet the criteria for having one.

Investment requirements

- Development and implementation costs: £250 000
- 3rd party supplier costs: £150 000

Impact of scheme

With real time data from multiple providers in a patient-centred view accessed as a matter of routine:

- Patients will be aware that they have a care plan and will feel more confident that their needs will be met in an urgent care situation
- Clinicians will be able to spend less time processing information to share , the risk of error will be reduced and the quality of information will improve
- Clinicians will be able to spend less time searching for information (already evidenced where OCS has been deployed).
- Real time care planning across organisations will reduce the risk of a deterioration leading to an urgent care event.
- Up to date medical information has already reduced the risk of inappropriate prescribing, clinical errors, unnecessary investigation, and unnecessary admissions; an increase in the quantity and scope of information will mean that patients will not be unnecessarily conveyed or admitted, and will be maintained on their usual care pathway more often.
- Information from community, mental health and social care will mean that, where attendance at A&E or admission cannot be avoided, discharges will be more timely and appropriate.

Feedback loop

- Data sets will be agreed by clinicians and approved by the CCG.
- Benefit measures will be agreed by the CCG; providers will be asked to own them and participate in benefits measurement activities.
- Providers will be asked to enable users to access and, when possible, contribute to the OCS.
- The OCS project team will deliver the product and measure uptake and benefits. The team will report to project board which will in turn report to the IM&T steering group.

What are the key success factors for implementation of this scheme?
• Urgent care services will have access to care planning information when they need it • The information is straightforward to access and is presented in a clear and predictable manner. • Urgent care services report that the information contained in the care plan successfully interrupted a usual triage response / prevented conveyance / prevented admission to hospital. • When fully implemented, clinicians are able to process data only once in order to record and share it.

Scheme ref no. 9
Scheme name:- Protecting Adult Social Care.
What is the strategic objective of this scheme?
Existing scheme. To protect adult social care, by avoiding the need to make further significant cuts in spending.
Overview of the scheme
The focus of this scheme will be 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. The focus in particular will be on frail older people (see evidence base below). This will include continuing investment in a range of activities, some of which are covered in more detail as part of other schemes within this Annex: • **Long term care packages** – as part of meeting the care and support needs of individuals, particularly in the face of increased demand for services that is likely to increase with the implementation of Care Act / funding reform changes from April 2016 onwards. • **Equipment –** investing in a wide range of assistive technology and more traditional equipment / aids to support people to live independently • **Intermediate care –** including reablement services to support people regaining independence. • **Services to support discharge** – such as assessing people in their own home after discharge rather than in hospital as shown to increase the likelihood of them regaining / retaining independence.
The delivery chain
These services are all commissioned by Oxfordshire County Council through the Older People's pooled budget, working closely with the CCG as appropriate. The services are provided by a mixture of community / voluntary sector providers, and Oxford Health NHS Foundation Trust, with all contracts closely monitored and managed by the County Council.
The evidence base
Long term care packages Since April 2011 the number of people receiving home care arranged by the council has risen from 1485 to 2142 people. The number of people receiving a direct payment has risen from 732 to 1473. This represents a 63% increase in people supported at home in 3½ years. (Source 25 November 2014 Briefing on the New Model for Home Care) Reablement However work by the department of health (CSED) suggested that a population the

size of Oxfordshire should expect to provide 3500 episodes of reablement a year, with half of these coming from people leaving hospital and half from people in their own home. This is based on a medium performing medium mature service. In Oxfordshire in the 12 months from October 2013, 1955 new episodes were of people who had been in hospital but only 865 from their own home (2820 episodes in total). This is 20% below the level expected. The reason for this was a lack of referrals to the service for people in their own home. To this end focus work to increase referrals is underway with GPs, the council's social and health care team and people providing information in local communities.

Intermediate Care Beds. We currently purchase 49 beds. OUH alone believe they need 14 discharges per week (work on 69 discharges). If each person were to last 4 weeks would take up 56 beds if they stayed 4 weeks. 10 admissions a week would take 40 beds of the 49 from acute. This is suggestive of a need for a comprehensive intermediate care strategy.

Services to support discharge
So far this year we have made 7 new packages per week. Home care delays have risen. At a rate of 9 per week delays have dropped. Need to increase from 7 to 9 per week.

Investment requirements

Impact of scheme

- Avoiding the need to make significant further cuts in adult social care funding.
- Reducing demand for adult social care.
- More people supported to live at home.
- Reduced placements in residential care.
- Reduced emergency admissions.
- Increased use of reablement.

Feedback loop

The County Council uses a range of mechanisms to gather feedback from service users and carers, including surveys, partnership forums, representatives on Joint Management Groups and other governance arrangements, and annual listening events. We also have good working relationship with Healthwatch Oxfordshire.

This is added to intelligence gathered from regular monitoring visits (all services are reviewed at least annually with more frequent monitoring on a risk based approach) and monthly reviews of activity and spending through the Joint Management Group. Appropriate action is agreed and implemented, and reported back to assess impact.

What are the key success factors for implementation of this scheme?

- Protection of adult social care, particularly spending.
- Delivery of high quality, joined-up services.
- Service user and carer satisfaction with services.
- More people supported to live independently at home.

Scheme ref no. 10
Scheme name:- Care Act Implementation
What is the strategic objective of this scheme?
To implement fully the Care Act 2014.
Overview of the scheme
Existing scheme. OCC has a well-established major change programme in place - the Adult Services Improvement Programme - to oversee the transformation of adult social care and implementation of reforms resulting from the Care Act. The programme includes a range of projects and developments specifically targeted at meeting the demands of the reforms, including: • Improving provision of online, telephone and face to face information and advice, including for self-funders • Developing a model of self-assessments, and development of an e-marketplace to drive choice and control for individuals • further support for carers in line with their right to access services, and meeting the anticipated increase in demand for assessments, building on existing services including carers breaks • improving existing processes and systems to avoid duplication and make them as effective as possible, including a new IT system for Adult Social Care • developing new ways of working that support integration, including devolving responsibility to locality teams • developing the local market to better meet the needs of individuals • ensuring the social care workforce is suitably trained, skilled and rewarded The BCF plan will help to fund a number of the above areas of work, either directly (in the case of improved IT systems and support for carers / meeting the cost of increased demand for assessments) or indirectly through releasing resources by meeting the costs of demographic pressures.
The delivery chain
This finding will be used by the County Council as provider of adult social care teams, and to commission a range of community, voluntary, public and private sector providers to deliver the required reforms.
The evidence base
Implementing the Care Act is a national requirement that is a key priority for OCC. It is also a requirement of the Better Care Fund agenda, and the funding allocation is set nationally. The projects and developments are based on existing best practice within Oxfordshire and across the country, and also the national evidence base developed by the Department of Health within the impact assessments that support the new legislation.
Investment requirements
£1.35m has been committed from the BCF to fund Care Act initiatives.

Impact of scheme
• To meet the cost of increased demand for assessments, particularly for carers assessments under the Act. • New and improved processes and systems to support and improved client experience – as well as financial benefits for the Council and better recording of client information. • Improved information, advice and signposting to support greater understanding and decision-making about how individuals can have their care and support needs met. • Enhancing the trained and qualified adult social care workforce, both within the Council and across providers.
Feedback loop
OCC uses a range of mechanisms to gather feedback from service users and carers, including surveys, partnership forums, representatives on Joint Management Groups and other governance arrangements, and annual listening events. We also have good working relationship with Healthwatch Oxfordshire. This is added to intelligence gathered from regular monitoring visits (all services are reviewed at least annually with more frequent monitoring on a risk based approach) and monthly reviews of activity and spending through the Joint Management Group. Appropriate action is agreed and implemented, and reported back to assess impact.
What are the key success factors for implementation of this scheme?
• Meeting new legislative requirements from April 2016. • Demand for social care services, including number of assessments and number people supported. • Service user and carer satisfaction with services. • Implementation of new IT system for adult social care by May 2015. • Improved diversity in the social care market. • Improved integration of and/or join up between health and social care services. • Improved accessibility to services to meet individuals care and support needs.

Scheme ref no.11
Scheme name: - Carers Breaks
What is the strategic objective of this scheme?
Existing scheme. The strategic objectives of the scheme are: 1. To support carers to continue to play an essential role in the development of health and social care services in Oxfordshire. (61,131 of Oxfordshire residents, - 9.4% of the population provide some unpaid care. 1 in 5 carers gives up work to care, carers are twice as likely to suffer ill-health as those not performing a caring role). 2. To identify more carers so that they are able to receive timely advice and support. 3. To provide respite in order to maintain health and wellbeing of carer and prevent carer breakdown. 4. To maintain the cared for person in their own home for as long as possible. 5. To prevent unnecessary hospital admissions and admissions to residential care. 6. To reduce hospital discharge delays. 7. To reduce referrals to social care. **8.** To reduce average cost of support plans.
Overview of the scheme
1. Model of Care a. Close working between OCC and OCCG to provide individual grants for carer support. b. Delivered through a. GP grants for carer breaks b. Adult Social Care grants for breaks and other services which provide respite functions to carers. c. Carers self-assess d. Carers provided with Direct Payment. **2. Which patient cohorts are being targeted?** a. Carers providing over 20 hours of care per week. b. Carers deemed to be at risk of a detrimental impact to their health and wellbeing. **c.** Carers at risk of carer breakdown.
The delivery chain
1. Commissioners are Oxfordshire County Council and Oxfordshire Clinical Commissioning Group. 2. Carers can self-assess via the Carers Oxfordshire website, or 3. Carers can registers as a carer with their GP and self-assess via their GP practice. 4. GP send appropriate applications to OCC. 5. OCC provides a Direct Payment to carers via either route and meet the above criteria. **6.** Carers required to provide evidence of expenditure of Direct payment.
The evidence base
Carers' survey: An evaluation of both the GP carer grants scheme and the adult

social care grants scheme was undertaken, 110 people responded to the survey. (55%) Use and benefits obtained from the schemes were assessed. The grant provided a wide range of supportive outcomes for carers. Many carers, when describing how they used the grant described how they felt about the recognition having the grant gave them as well as the practical help it provided.

Personalisation and carers: The importance of breaks for carers to continue their caring role has been repeatedly highlighted and the Government recommends that one of the most effective ways of supporting carers is through providing them with breaks (**HM Government (2010), Recognised, valued and supported: next steps for the Carers' Strategy. London: Centre for Information.).**

The funding for breaks is designed to offer more than simply time off caring. It offers the chance for the carer to do something for themselves. The breaks are designed to be tailored to the carer's needs as the result of a carer's assessment, which considers all the carer's choices and needs, including health, work, leisure, learning and other commitments

Progressing Personalisation. (2012) Carers Trust: Highlighted the barriers and opportunities for carers and local authorities in the delivery of carers' breaks through direct payments. The numbers of carers identified and supported in Oxfordshire who are non FACS eligible continues to rise in spite of a general trend for many Authorities to be concentrating spending on those with critical and substantial needs

In the **Review of personal budgets and direct payments for carers,** Think Local, Act Personal (TLAP) have looked at how personal budgets are being used and suggest that the essential component is agreeing outcomes that the personal budget is supposed to address. TLAP recommends that to allow flexibility and choice, outcomes need to be expressed in the broadest terms; The model of breaks follows this recommendation.

Investment requirements

Source of Investment	**Amount**
Social Care Grant	354,000
Life of Your Own Grant	342,000
GP grant	604,000
Total	1,300,000

Impact of scheme

Preventative outcomes remain difficult to measure, however carers report the use of the grant has reduced isolation, maintain contact with families, and allowed a break from caring. We are measuring the following some of which we understand to be attributable to this preventative approach.

1. More carers identified in GP practices (GP register of carers).
2. More Carers able to access a break making the caring role sustainable.
3. Cared for remains in community for longer (Care home data).
4. Reduced delays in hospital discharge.

Feedback loop

We have administered the scheme through both the 72 GPs surgeries and through the Local authority customer services centre. This has been reviewed jointly with under the carers' joint strategy Group. A workshop considered the outcomes and in preparation for the Care Act additional changes will be introduced to ensure equity

and consistency in the scheme: • The number of carers breaks awarded each year is measured. • Carer satisfaction is measured in the national carers' survey. • Oxfordshire carers satisfaction is measured in the local carers' survey.
What are the key success factors for implementation of this scheme?
• Carers report that they feel valued and supported to continue their caring role. • Carers report that Self-Assessment is simple to administer and they feel in control of the process. • More carers are identified through the process.

Scheme ref no. 12
Scheme name: Primary Care
What is the strategic objective of this scheme?
New schemes. This scheme embodies Oxfordshire's CCG's commitment to support a range of GP-led initiatives designed to extend GP services and improve the patient's experience of primary care. Collectively the initiatives will: improve education and support to people with long-term conditions to promote self-care management; respond urgently to prevent deterioration in those with a known long-term condition; increase primary care provision during periods when the health and social care system is experiencing significantly increased pressure according to the Oxfordshire Escalation Framework; and support improved flow through bedded care and offer alternatives to A&E attendance and non-elective admission. This scheme includes the Oxfordshire proposal in response to the Prime Ministers Challenge Fund.
Overview of the scheme
The scheme includes: • **Complex care teams** – GP-led teams that will maintain personal care plans and support urgent assessments before 1pm when required. • **Sub-locality hubs** – Collaborative working between practices that will increase capacity for same day assessments and enable GPs to have more clinical facing time with those who have long-term conditions. • **Improving health literacy** – Ageneral practice interactive web-based health site providing specific condition guidance and sign-posting to other support. • **Extended access hours i.e. linking out of hours to primary care escalation** – Enabling GP services to be available across the county from 8am – 8pm. and use of duty doctor at practices closest to EDs to support ED turnaround and offer patients alternative to ED attendance. • **Support of early discharge - B**y undertaking home visit on the same / next day of higher acuity patients released from bedded care In addition the Emergency Duty Team (out of hours OCC social work response), together with a review of control centres for safeguarding, EDT, crisis, telecare and equipment provision, will ensure a consistent social care response to primary care requests for out of hours social care support. To complement extended opening hours OCC will require home care providers to respond to care package requests in the evening and over the weekend. In addition OCC recommissioned home care services will be required to put in place an emergency care package within 24 hours and standard care packages within 48 hours.
The delivery chain
Commissioners are OCCG. The main providers are GP practices.
The evidence base
Various national initiatives are ongoing to support increased access to primary care

during out of hours periods or to support particular cohorts of patients, such as:

- NHS England Directly Enhanced Services.
- Prime Minister's Challenge Fund.

Investment requirements

Further work is underway to fully identify investment and saving opportunities.

However an example of the cost of extended opening -

a) £200 per hour cost, to include receptionist, 1 nurse and 1 GP for 3.5 hours (1830-2200).

b) Either offering 4 practices (two in Oxford, two in Banbury) an evening, or 2 sets of staff in one practice; Total cost = £800 per evening for 80 days a year = £64,000

GP home visit on the same / next day of discharge

b) Cost of £100 per additional home visit specific for this cohort of patients

c) It is estimated that this will support the additional discharge of 5 patients daily such that c.30 patients per week would be supported home early. Across 6 weeks, this equates to 180 patients.

d) Total cost of GP visits = £18,000

TOTAL COST = £82,000

Impact of scheme

Extended opening -

Attendance will save £64.50 estimated as average cost of minor ED attendance (VB09Z Cat 1 investigation with Cat 1-2 treatment = £72) ; (VB11Z No investigation with no significant treatment = £57).

11,200 patients avoiding ED attendance at an average cost of £64.50 = **£722,400**

1% reduction in non-elective admissions from this cohort of patients = 112 admissions avoided. Overnight estimated cost of NEL admission = £500. Savings associated with NEL admission reduction = **£56,000**

GP home visit on the same / next day of discharge

It is estimated that this will support the additional discharge of 5 patients daily such that c.30 patients per week would be supported home early. Across 6 weeks, this equates to 180 patients.

Reducing LOS by 1 day for patients in a bedded care setting (estimated cost £500) will produce savings of **£90,000**

TOTAL IMPACT OF SCHEMES: £786,400

Feedback loop

The development of the primary care federations will be monitored through the SRG. The anticipated benefits including performance against non-elective admission, A&E attendance and DToC, will be monitored through KPIs as part of the SRG dashboard.

Once developed the schemes will be included in the established contract monitoring cycle.
What are the key success factors for implementation of this scheme?
• Reduction in A&E attendances. • Reduction in non-elective admissions. • Reduction in DToC.

ANNEX 2 – Provider commentary

For further detail on how to use this Annex to obtain commentary from local, acute providers, please refer to the Technical Guidance.

Oxford Health Foundation NHS Trust.

Name of Health & Wellbeing Board	Oxfordshire Health and Wellbeing Board.
Name of Provider organisation	Oxford Health Foundation NHS Trust.
Name of Provider CEO	Stuart Bell.
Signature (electronic or typed)	

For HWB to populate:

Total number of non-elective FFCEs in general & acute	**2013/14 Outturn**	
	2014/15 Plan	
	2015/16 Plan	
	14/15 Change compared to 13/14 outturn	
	15/16 Change compared to planned 14/15 outturn	
	How many non-elective admissions is the BCF planned to prevent in 14-15?	
	How many non-elective admissions is the BCF planned to prevent in 15-16?	

For Provider to populate:

	Question	Response
1.	**Do you agree with the data above relating to the impact of the BCF in terms of a reduction in non-elective (general and acute) admissions in 15/16 compared to planned 14/15 outturn?**	
2.	**If you answered 'no' to Q.2 above, please explain why you do not agree with the projected impact?**	
3.	**Can you confirm that you have considered the resultant implications on services provided by your organisation?**	

Oxford University Hospitals NHS Trust.

Name of Health & Wellbeing Board	Oxfordshire Health and Wellbeing Board.
Name of Provider organisation	Oxford University Hospitals NHS Trust.
Name of Provider CEO	Sir Jonathan Michael.
Signature (electronic or typed)	

For HWB to populate:

Total number of non-elective FFCEs in general & acute	**2013/14 Outturn**	
	2014/15 Plan	
	2015/16 Plan	
	14/15 Change compared to 13/14 outturn	
	15/16 Change compared to planned 14/15 outturn	
	How many non-elective admissions is the BCF planned to prevent in 14-15?	
	How many non-elective admissions is the BCF planned to prevent in 15-16?	

For Provider to populate:

	Question	Response
1.	**Do you agree with the data above relating to the impact of the BCF in terms of a reduction in non-elective (general and acute) admissions in 15/16 compared to planned 14/15 outturn?**	
2.	**If you answered 'no' to Q.2 above, please explain why you do not agree with the projected impact?**	
3.	**Can you confirm that you have considered the resultant implications on services provided by your organisation?**	