# Oxfordshire Better Care Fund Plan 2022/23: narrative plan

## Health & Wellbeing Board: Oxfordshire

## Introduction: development of the Plan

1. Partners involved in the development of this Plan:
    a. Bucks, Oxfordshire and Berkshire West ICB, including GP reps from Primary Care Networks [ICB]
    b. Oxford University Hospitals NHSFT [OUH]
    c. Oxford Health NHSFT [OH]
    d. South Central Ambulance Service [SCAS]
    e. Oxfordshire County Council (integrated commissioning, operations and Public Health) [the Council]
    f. West Oxfordshire DC [WODC]
    g. Oxford City Council [the City]
    h. South Oxfordshire DC/Vale of White Horse DC [S&VDC]
    i. Cherwell DC [CDC]
    j. Oxfordshire Association of Care Providers [OACP]
    k. Oxfordshire Care Homes Association [OCHA]
    l. Age UK Oxfordshire [AUK]
    m. Order of St John Care Trust [OSJ]
2. A wider group of stakeholders have been involved in the development of specific schemes including independent providers (eg nursing homes providing pathway 2 discharge beds, GPs providing in-reach medical support to those beds) and a wider cross section of the voluntary and community sector in relation to the development of social prescribing and prevention (including Oxfordshire Mind, CAB).
3. The development of the BCF plan has been led by officers from the Oxfordshire Integrated Commissioning team hosted by Oxfordshire County Council. For 2022-23 the Council determined that we should extend the planning process to include a wider group of stakeholders in both the planning as well as consultative stages. A workshop of interested parties was held in March which led to a fortnightly planning group that has developed the schemes and plan that are set out below. This has included DFG and housing leads from the Districts.
4. In 2022-23 the BCF plan for Oxfordshire forms part of and complements the system Integrated Improvement Plan. These plans have been developed and overseen by the system-wide Urgent Care Delivery Group [UCDG] reporting to the Oxfordshire Improvement Leadership Board [OILB]. OILB is the reformed AEDB for Oxfordshire. Co-ordination of this activity has been overseen by a senior leaders' group from the Council, the ICB, OUH, OH and SCAS.
5. The demand and capacity plan and target metrics in the BCF plan have been reviewed by UCDG and agreed by OILB. OILB will monitor, assure and implement remedial plans associated with the BCF metrics as part of its wider remit for system performance.

## Executive Summary: Oxfordshire's key priorities for 2022/23

6. Oxfordshire's key priorities for 2022/23 are
    a. **Winter/surge capacity**: keeping social care and the hospital flow going through winter
    b. **Conveyance/admission avoidance**: stopping people needing to go to hospital to get the care that they need-*right care, right place, right time*
    c. **Improving discharge pathways**: helping people get Home First as soon as they no longer need a hospital bed-*right care, right place, right time* and *safe and well at home*
    d. **Addressing health inequalities, including in hospital pathways**: making our pathways work for everyone, including younger people, people with mental health needs, people with dementia; people with learning disability and/or autism; homeless people
    e. **Integrating care and support around people in their own home**: building on existing links with district councils and developing our offer around equipment, the use of technology, and the use of extra care housing to keep people *safe and well at home*
    f. **Unpaid carers and prevention**: further development and implementation of the Oxfordshire Way; creating the community capacity and the social prescribing to link people to it; and responding to unpaid carers' concerns re dementia support and practical help that supports them as carers and so help people keep people *safe and well at home*
7. We will develop our approach to demand and capacity planning through a focus on asset- and strengths-based approaches in care assessment and delivery as described in the *Oxfordshire way*, and continue to develop deployable community assets outside of standard care settings and approaches.
8. We will align the Better Care Fund plan with the system urgent care Integrated Improvement Plan. The Better Care Fund *investment* plan is focussed on those areas that are not covered by external funding; but overall the Plan is aligned to the system Integrated Improvement Plan.
9. The 2022/23 Plan is different from that in 2021/22 in that
    a. It has been developed with a much wider group of stakeholders who are involved in co-producing the specific schemes
    b. It has a greater focus on prevention and on Carers
    c. It is informed by an approach to demand and capacity that will be developed further during 2022/23
    d. It is realistic but ambitious regarding the opportunities to improve outcomes for our population and support more people at the right place at the right time, and in a way that support their ongoing independence in their own community

## Better Care Fund Priorities for 2022/23

10. Oxfordshire has consolidated changes rolled out in the 2021/22 plan and expanded them as set out below. The key challenges that have faced the Oxfordshire system are as follows.

11. Our experience of winter 2021/22 and the evidence of the developing demand and capacity plan is that
    a. We have insufficient capacity in key areas (mainly reablement/domiciliary care/P1) to meet demand in the traditional way.
    b. This is driven by workforce constraints which are common to NHS and social care providers
    c. Therefore, we need to work differently to manage that demand, both in terms of admission avoidance and in terms of discharge from hospital
    d. We need to focus particularly on the opportunities to work in a preventative and strengths- and asset-focussed way to help people make the most of what they have within their own communities
    e. We will continue to develop our ability to understand demand and map and develop the capacity that makes a difference as set out below. We have reviewed the High Impact Change model as set out below at para in support of this.

12. The withdrawal of Hospital Discharge Policy funding after March 2022 means that our surge planning for winter 2022/23 needs to be funded through alternative routes. At the time of writing this Plan funding for additional beds and for other initiatives to support flow may be available from other NHS sources. However, we have left a contingency in the BCF plan for 2022/23 which will be deployed on further developmental projects if not needed for this extra capacity.

13. The demand and capacity planning exercise within the BCF has highlighted a number of key issues for Oxfordshire
    a. Our reliance on bed-based pathways to support discharge
    b. Our lack of Pathway 1 capacity driven by workforce challenges
    c. Our need to understand better the relationship between the needs of the individual and where s/he is placed in terms of the discharge pathways. The pathway prescription may be driven by availability rather than needs
    d. Our need to move to a more anticipatory model to avoid unmanageable pressures on the discharge pathway
    e. And the need to quantify and then deploy a wider set of resources within the community.

14. To develop our use of demand and capacity modelling we intend to
    a. Use the BCF funding 2022/23 to engage a specialist agency that will support models that identify and deploy capacity
    b. Use Urgent Care funding to employ a dedicated urgent care data analyst to work with organisational Business Intelligence leads to improve the flow and system view of key data

15. The Plan has been approved by the Oxfordshire Improvement Leadership Board (the successor to the A&E Delivery Board) which has agreed the following system priorities:

a. **Winter/surge capacity**: keeping social care and the hospital flow going through winter
b. **Conveyance/admission avoidance**: stopping people needing to go to hospital to get the care that they need-*right care, right place, right time*
c. **Improving discharge pathways**: helping people get Home First as soon as they no longer need a hospital bed-*right care, right place, right time* and *safe and well at home*
d. **Addressing health inequalities, including in hospital pathways**: making our pathways work for everyone, including younger people, people with mental health needs, people with dementia; people with learning disability and/or autism; homeless people
e. **Integrating care and support around people in their own home**: building on existing links with district councils and developing our offer around equipment, the use of technology, and the use of extra care housing to keep people *safe and well at home*
f. **Unpaid carers and prevention**: further development and implementation of the Oxfordshire Way; creating the community capacity and the social prescribing to link people to it; and responding to unpaid carers' concerns re dementia support and practical help that supports them as carers and so help people keep people *safe and well at home*

## Key changes and developments from the 2021/22 Plan

16. During 2021/22 Oxfordshire implemented key system initiatives to support the delivery of the BCF which we will continue to develop to meet those priorities identified above in 2022/23:
    a. An integrated commissioning team across Health, Social Care (children and adults) and Public Health and hosted by the Council. **All commissioning of activity funded from the Oxfordshire BCF is now delivered by a team of jointly funded commissioners acting on behalf of the ICB and Council.** The s75 agreement between the Council and the ICB is broader than the BCF and covers all age mental health, adult learning disability and/or autism, all adult social care (except community operational teams), NHS continuing healthcare and a range of preventative and community health services which support deliver of the BCF metrics. The current s75 will be replaced by a new version from 1 November 2022 which consolidates and extends the commitment to integrated commissioning in line with our ambition to create a life stage, tiers of need approach to service delivery.
    **b.** A joint funded System Director of Urgent Care (funded from BCF). **Oversight and assurance of Oxfordshire's system performance sits with this post reporting to OILB. The post is part-funded from the BCF.** This post has developed the system Integrated Improvement Plan which is designed to implement NHS mandated changes in urgent and emergency care especially in relation to admission avoidance through the model of Virtual Wards and the implementation of Urgent Community Response. The BCF Plan has been aligned to this urgent care approach and from 2023 will be fully integrated.
    c. A Home First MDT (**funded from BCF**) to support discharge home from hospital and management of people at risk in the community. The new team went live on 1 October 2021. **The integrated team comprises Council staff working with OH community therapists and voluntary sector**.

d. The Home First MDT is working in partnership with new strategic providers of reablement and domiciliary care commissioned by the County Council and CCG under Live Well at Home contracts. Live Well at Home also went live on 1 October 2021. **During 2022/23 the providers have worked into daily MDT huddles designed to assure reablement plans and map capacity against demand**. **These contracts are funded in part from the BCF**

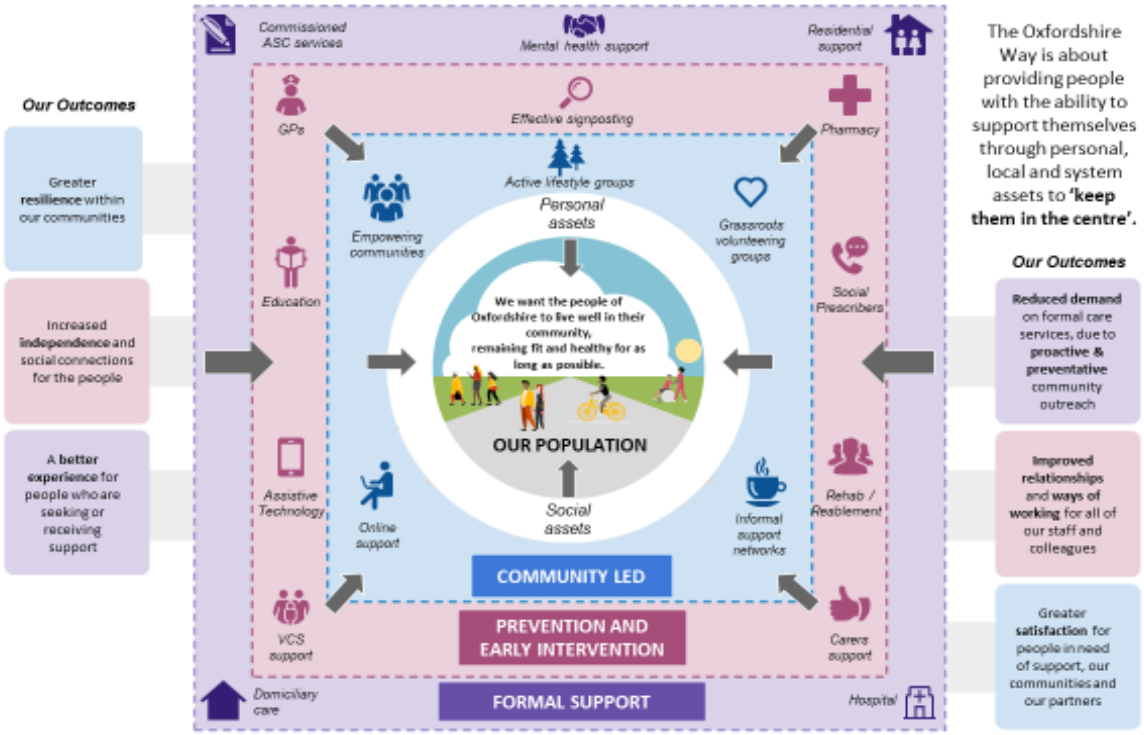
e. The Home First MDT works closely with existing AUK support into the hospital discharge pathways to complement people on Pathway 1 and support people on Pathway 0. **This is funded from the BCF**

**f.** Oxfordshire began delivery of the Ageing Well Urgent Community Response from 1 October 2021. **This is funded outside of the BCF but closely aligned to it; and in 2022/23 we are investing from the BCF to extend the reach of the service during winter.**

g. The Council has developed with partners a Transformation Programme called *The Oxfordshire Way* in 2021 to develop strengths-based approaches to assessing and planning support for people in the community within adult social care teams. **During 2022/23 we have worked with the voluntary and community sector to expand this work. In 2022-23 we are working with the voluntary sector and primary care to align the Oxfordshire Way with the implementation of NHS Social Prescribing in Oxfordshire**. We are working with the ICB and local primary care networks to map the inputs from Social Prescribing and community capacity into the implementation of Anticipatory Care Planning from April 2023.

h. **The BCF funds Community Capacity grants, community development, advice information and support and the development of micro-enterprises that act as an alternative to formal care and support people's independence within their own community**. This capacity underpins the implementation of the Oxfordshire Way and NHS Social Prescribing. It is aligned to Public Health funding (e.g., in relation to healthy place-shaping, targeted interventions around high needs localities and preventative programmes around falls). It will constitute an "offer" to primary care networks to develop an integrated approach to social prescribing in the County.

**We have developed a compelling future narrative and roadmap for the transformation of Adult Social Care and the role it will play within our communities - The Oxfordshire Way**




17. A review of performance within Pathway 2 against a discharge to assess approach has identified changes that will increase the proportion of people who return home and within a shorter timeframe. **We have developed a model with additional therapy input, greater co-ordination capacity in care home providers and will implement increased use of assistive technology in 2022/23, funded from BCF**

## Governance of the Better Care Fund in Oxfordshire

18. The Oxfordshire Health and Well-Being Board has overall responsibility for the Better Care Fund Plan and will review and approve the plan at its meeting on 6 October 2022. The HWB has delegated responsibility to the Council Corporate Director for Adult Services who briefed the Chair of HWB and the Cabinet Lead for Adult Social Care prior to submission of this plan.
19. Oxfordshire has developed a new s75 NHS Act 2006 agreement that incorporates the Better Care Fund. This new agreement has been approved by Cabinet at the Council and will be approved by the Bucks, Oxfordshire, and Berks West Integrated Care Board at its meeting in November 2022. The new agreement which incorporates the funding deployed within this Plan will commence on 1 December 2022.
20. The development of this Plan and proposed trajectories for the BCF metrics; the allocation of funding against the schemes in the Plan; and the demand and capacity plan has been overseen by the system Urgent Care Delivery Group and approved by the system wide Oxfordshire Improvement Leadership Board (the

successor to the A&E Delivery Board). The OILB will in due course report to the Oxfordshire Place Based Partnership Board when established.

21. Commissioning oversight of the Plan and pooled budgets in the s75 NHS Act 2006 is delegated by the Council and the ICB to the Joint Commissioning Executive. The Deputy Director, Integrated Commissioning is the Pooled Budget Manager for the s75 agreement (including the Better Care Fund) and accountable to the Joint Commissioning Executive. Within the s75 agreement, the commissioning of Better Care Fund Plan services is delegated by the ICB to the Council via the Health, Education and Social Care integrated commissioning team. This team is led by the Deputy Director and hosted by the Council.
22. Proposals in respect of the Disabled Facilities Grant and Home Improvement Agency are developed by the County Housing Forum, a joint meeting of District Council leads and the Lead Occupational Therapist Oxfordshire County Council and the integrated housing OTs and lead commissioners.

## Overall approach to integration

23. **Joint priorities** for the BCF Plan have been agreed by the system at OILB as at para 15.
24. **Commissioning of services funded via the BCF is wholly integrated**, with 19 joint funded posts hosted by the Council and led by the Deputy Director, Integrated Commissioning who reports to the Executive Director of Place for the ICB and the Corporate Director of Adult Services for the Council. The integrated commissioning team is overseen by a Joint Commissioning Executive [JCE] made up by the Directors of Adults, Children and Public Health for the Council and the Directors of Place and Delivery for the ICB, together with Directors of Finance for both organizations.
25. The JCE is responsible to the Council and the ICB for the pooled budget spend which is in total £390m. This covers all age mental health, adult learning disability and/or autism, adult social care, and a range of health services for adults and older adults. **The ICB delegates strategic commissioning against this pooled fund to the Council within the new s75 agreement. The BCF pool funds the following joint initiatives that are managed by the Council on behalf of the partners**
    a. Live Well at Home reablement and domiciliary care services
    b. Pathway Way 2 step down beds (additionally joint funded by OUH)
    c. Pathway 2 discharge multi-disciplinary team
    d. Dedicated specialist dementia nursing home beds
    e. Community Equipment Services (additionally joint funded by OH and OUH)
    f. Dementia Support Services
    g. Carers support services (including direct grants)
    h. Falls pathway
26. The overall approach to integration is to develop multi-disciplinary teams around the needs of the individual and structures that work in an integrated way for case management and resource deployment across the system. Daily flow is managed by a multi-agency meeting led by the Deputy Director Operations for

the Council and the system Director of Urgent Care. Strategic planning and delivery of services is led from the OILB.

27. The BCF funds specific integrated services as follows
    a. Home First MDT bringing together reablement service providers, Council and NHS staff
    b. An integrated care planning approach for people in Pathway 2 bringing together acute hospital discharge teams, community therapy in-reach, social care in-reach, primary care, and nursing home staff. The BCF is funding an expanded therapy-led model in 2022/23.
    c. Homelessness step down services that bring together mental health, voluntary sector floating support, social care and health. The BCF is funding an expansion to this service to create an integrated case management system and to create a step-up facility to avoid admissions.
    d. Support to Care Homes: in reach services provided by OH Care Home Support Service which is aligned with primary care as part of the delivery of the NHS Enhanced Healthcare in Care Homes Direct Enhanced Service. In 2022-23 this is being expanded via the BCF in 2 pilots to extend Speech and Language Therapy and mental health support which will support admission avoidance and timely discharge home especially in cases related to delirium.
    e. Falls pathway. This is provided jointly by OH community therapy services and the voluntary sector led by Age UK. This is being expanded in 2022-23 as part of a review jointly between the BCF and Public Health to extend the preventative offer around screening and strength and balance classes and to deploy assistive technology for people who are at risk of falling. The falls pathway touches on many organisations and we will additionally be working with district councils and housing providers to improve our Falls response within the BCF plan.
    f. Community capacity: BCF funding is being used to bring together voluntary sector advice services delivering social prescribing, advice, and information with community-based services working to support social care and primary care in managing demand and increasing independence and resilience. This offers the opportunity to align BCF and NHS primary care ARRS funding to increase scope and impact
    g. Integrated occupational therapy support to District Council Home Improvement Agency and Disabled Facilities Grant functions

*Aligned Plans*

28. In 2022/23 the Oxfordshire System Urgent Care Director has led on an Integrated Improvement Plan to assure delivery of key NHS policy objectives (e.g. Virtual Ward) in the County. This work has been funded by national and local dedicated NHS funding. The BCF Plan has been designed to complement this Plan where it supports delivery, specifically where this impacts on the BCF metrics:

| Improvement Plan theme | Programme | BCF aligned contribution |
|---|---|---|
| | Anticipatory Care | The Oxfordshire Way |

| Improvement Plan theme | Programme | BCF aligned contribution |
|---|---|---|
| Better support for people at home | | Community capacity and capability |
| | Primary care virtual ward | Voluntary sector support to primary care MDT |
| Winter surge | Increased referrals to Urgent Community Response | Investment to expand service |
| | Acute virtual ward | Hospital at Home services |
| | Reduced Length of Stay in ED | Homelessness step-down beds<br>Investment in Urgent Community Response<br>Increased patient transport for early morning discharge and settling in at home |
| Aligning demand and capacity | Bed-based D2A | Increased therapy input in MDT<br>Additional nursing home staff capacity<br>Use of assistive technology to support journey home |

29. The integrated deployment of the NHS national and local funding together with the BCF has increased the scope of the planned interventions in
30. Similarly, the BCF Plan has been developed with the support of Public Health and Primary Care and aligns funding from both to support delivery of the metrics especially in relation to prevention (NHS Social Prescribing and Falls).
31. From 2023/24 we intend to integrate these planning approaches further subject to any specific requirements from NHS England.

## Implementing the BCF Policy Objectives (national condition four)

### *Enable people to stay well, safe and independent at home for longer*

32. **Demand and capacity to support community interventions**. Development of the demand and capacity template has highlighted the following issues:
    a. **Voluntary sector support**. We have captured the commissioned capacity funded by the BCF, but this is a subset of a much wider potential offer that is being funded in part from the BCF (Community Capacity grants) and from NHS and other forms of social prescribing. We need to develop a better understanding of this capacity, whether it can be deployed to support admission avoidance and then how to count it. This work is being progressed through our prevention workstreams (see para 33a)
    b. **Urgent Community Response**. Demand on UCR has been increasing and now exceeds the national expectation of 13 pick ups per day. Within the BCF we plan to invest to increase those pick ups and provide greater out of hours resilience especially in the early mornings. It is likely that the service will need to be further expanded in 2022/23.
    c. There is a **shortfall of reablement** as discussed below at para 35c

d. **Step up bed provision** is provided via our emergency ambulatory assessment units. This capacity meets demand except when these beds have been redeployed into Pathway 2 and become unavailable

33. Oxfordshire will deliver right care, right place, right time through the following initiatives

a. **Prevention**. Supporting people to live independently in their own community.

i. Oxfordshire has developed the *Oxfordshire Way,* a strengths and asset-based approach to helping people live independently in their own community. This approach is delivered in partnership with Voluntary and Community Services and funded by the BCF. In 2022-23 we have reviewed and expanded a grants programme to increase community capacity and capability especially in areas of deprivation and amongst groups who are most at risk of isolation and decreasing physical activity. This approach grew out of the local response to covid, and in recognition that we needed to enable more people to live independently if we are going to manage the demand for social care at a time of constraint driven by workforce pressures. The Oxfordshire Way runs through our approach to care planning for people who have needs under the Care Act and we are looking for alternatives to long-term care until this is in the best interest of our population.

ii. This approach is being expanded in 2022/23 by aligning the development of the Oxfordshire Way with NHS Social Prescribing and similar initiatives led by District Councils and Public Health (especially around Healthy Place Shaping and Green Social prescribing). We have established a multi-agency Promoting Independence and Prevention Group that brings together these commissioners with primary care and the voluntary sector to develop alignments between what is already there and to identify gaps. Specifically, the group is developing an approach that integrates the community offer with the implementation of NHS Social Prescribing to assure that there is information and advice, resources that people can use, and support for those who need it to access those resources to support independent self-care. The group is also developing approaches that encourages the development of "bottom up" community capacity that improves individual, community and system resilience, by adopting the characteristics of community connectors and local area co-ordination.

iii. Within this preventative approach we have focussed on the needs of Carers in response to feedback in the 2021/22 national Carers survey. Working with Carers groups we are funding within the BCF an expansion of dementia support to include help and support for people with mild cognitive impairment and expanding our practical support and respite offer to Carers. Our ability to support carers both "makes the NHS and the care sector go further" but also recognises

that a key driver of long-term admission to residential settings is carer breakdown.

b. **Anticipatory Care Planning**. This is a key plank of the system Integrated Improvement Plan and is led in Primary Care Networks based on population health management risk stratification tools. The BCF is supporting this approach by funding the community services (above) that will help deliver effective Social Prescribing and the Community Information Network that delivers the Oxfordshire Way and advice and information to help people support themselves with informal support.
    i. We are reviewing our falls pathway in 2022-23. Oxfordshire is an outlier for falls that lead to fractures and we believe that our performance in relation to metric 8.1 is also impacted significantly by fallers at home where no fracture takes place. We are working with primary care to increase referrals into strength and balance classes funded by BCF and delivered in the voluntary sector.
    ii. We are working generally with our provider sector to increase capability around the management of people with acute long-term needs. As part of a refresh of our approach to contracting with care homes, we are redesigning the care bandings with them and developing standards and identifying gaps in managing the levels of need identified in the banding. This will inform how we deploy the BCF in 2023/24.
c. **Enhanced support to people at risk**. Within the Integrated Improvement Plan Oxfordshire is creating primary care virtual wards that bring together primary care, community health, social care and dedicated co-ordination to provide short-term management of people at risk of admission to hospital. These will be fully implemented across the County by March 2023. The BCF is funding voluntary sector input into these structures and they will draw on the community capacity set out above.
    i. The review of the falls pathway will also identify people at risk especially those people at risk in care homes and will develop classes that support residential settings in managing these risks
    ii. The BCF is funding additional inputs into care homes that support management of speech and language issues (compromised swallow) and complex dementia and mental health presentations. This approach is both about patient level intervention and working with care homes to increase their capability and confidence to manage these situations
d. **Virtual ward approaches to avoid conveyance and admission**. Within the Integrated Improvement Plan this is led by Urgent Community Response in partnership with the ambulance service and the BCF funded Hospital at Home services. We are using the BCF to extend the Urgent Community Response offer so that it can respond to early morning (pre-0800) referrals and to provide an extended transport service offer so that we can take people home and settle them in after an overnight attendance at the acute.

We are also extending for winter the capacity of our ambulatory assessment units in the community.

i. Within the Virtual ward the ambulance service and urgent community response have designed improved protocols to avoid conveyance where people have fallen. This will be incorporated within our revised falls pathway

ii. We have extended the deployment of our BCF funded equipment service to increase locality stores of key kit to avoid the need for conveyance

iii. We are introducing a homeless step-up response building on the learning and success of our discharge model. Funded by the BCF this will develop housing and support that particularly can support diversion from ED for homeless people where admission may otherwise happen owing to the need to manage a clinical need (e.g. dressings)

34. These approaches together will impact on BCF metrics 8.1, 8.4, and 8.5 as follows

a. **BCF Metric 8.1**. Oxfordshire is planning for a 2% reduction in activity in 2022/23. There was a significant reduction in non-elective activity in M4 2022/23, but we have adopted a prudent approach that assumes a 6% growth in projected activity against the current trajectory in Q4.

b. **BCF metric 8.4**. Oxfordshire has reduced long-term placements in residential settings for 2 years and we project a continued reduction for 2022/23 based on our approach to strengths-based assessment in line with the Oxfordshire Way, extra care housing as alternative settings and a low rate of pathway 3 discharges from hospital

c. **BCF Metric 8.5**. We have seen improved impact from reablement and expect that to continue based on current performance with delivery of recovery.

| | | 19/20 | 20/21 | 21/22 | 22/23 | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Actual | Actual | Actual | **Annual Plan** | Q1 | | Q2 | | Q3 | | Q4 | |
| | | | | | | Plan | Actual | Plan | Actual | Plan | Actual | Plan | Actual |
| 1 | Unplanned hospitalisation for chronic ambulatory care sensitive conditions | 745.1 | 622 | 734.4 | **720** | 175 | 185 | 350 | | 535 | | 720 | |
| 4 | Long term support needs of older people met by admission to residential and nursing care homes per 100,000 population | 597 | 442 | 370 | **352** | 85 | 67 | 170 | | 261 | | 352 | |
| 5 | % of older people (65+) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services | 67.2% | 62.0% | 81.0% | **84%** | n/a | | | | | | 84% | |

35. Oxfordshire Improvement Leadership Board approved these trajectories at its meeting on 13 September and will monitor delivery of these targets

## *Improving discharge*

36. As part of the BCF planning round for 2022/23 we have reviewed our progress against the High Impact Change domains as follows

| **High Impact Domain** | **Oxon self-assessment** | **Action in BCF plan** |
|---|---|---|
| Early discharge planning | Partly in place | Development of Transfer of Care function within system Integrated Improvement Plan |
| Monitoring and responding to demand and capacity | Partly in Place | Plan to engage external consultants to support a needs-based approach to demand modelling and capacity |
| MDT to support discharge | In place | MDT in place for HF and P2 discharge |
| Home First D2A | In place | Home First MDT in place for P0 and P1 |
| 7 day working | Partly in place | Additional capacity to support discharge and admission avoidance 7 days |
| Trusted assessment | Not in place | New service commencing Q3 22/23 |
| Engagement & Choice | In place | |
| Improved discharge to care homes | Partly in place | BCF funding for mental health/SALT in addition to existing Care Home Support Service<br>Supported by Trusted Assessment |
| Housing & related services | Partly in place | BCF pilot to deploy extra care housing i discharge pathway<br>BCF funded activity in partnership with Districts re homelessness: step down Beds in place; step up beds start Q3 |

37. The Oxfordshire system is constrained by workforce pressures to support discharge into Pathway 1. We are working with our providers to improve this through a range of recruitment and retention initiatives funded by the BCF, but as in the example of the Oxfordshire Way we have challenges that have to be managed by alternative approaches to discharge

38. **Demand and capacity to support discharge**. Development of the capacity template has highlighted the following issues

a. The BCF funds **VCSE support to discharge in Pathway 0** (and it also supports Pathway 1). There is currently no waiting list for intervention and so capacity is judged to match demand. This will need to be reviewed as we seek to shift capacity from Pathway 1 to Pathway 0

b. **Urgent Community Response support to Pathway 0**. Currently there is a relatively small referral rate to UCR from ED. This should increase during 2022/23 with the development of the virtual ward model. The BCF is paying for additional capacity in UCR during 2022/23

c. **Reablement (Pathway 1).** Oxfordshire currently has insufficient capacity to meet demand largely due to workforce issues within our strategic providers. An action plan is in place to mitigate this which is in part reflected in this plan: review of Pathway 1 referrals by the Home First MDT to divert patients to Pathway 0 supported as in (a) above; increase in workforce from international and other recruitment plans; step down from reablement from review of plans and progress at the earliest opportunity; alternative use of extra care flats for "complex pathway 1". Our recovery to no long-term care rate is above the national target of 67% and we will work with providers to increase this in line with metric 8.5. There is provision in our BCF plan for additional P2 bed surge capacity as a mitigation to the Pathway 1 shortfall.

d. **Pathway 2**. In the BCF plan as set out below we are redesigning part of the step-down bed pathway to increase flow. At the time of writing this plan we have a technical gap in producing a demand profile for Pathway 2 beds which will be resolved during Q3.

e. **Pathway 3**. There is a surplus supply of residential and nursing home beds in Oxfordshire and capacity meets demand except for in complex needs relating to dementia. Within the BCF plan we are investing in mental health support to care homes to support discharge to beds for more complex patients and working with providers (via the BCF funded Care Home Support Service) to increase capability around this cohort.

39. These findings and the review of the High Impact Change Model have driven our approach to improving discharge pathways as part of the BCF plan

a. The hospital Care Team is working with physios, the voluntary sector and Urgent Community Response in ED to support discharge home rather than admission.

BCF is funding patient transport capacity and extended mental health capacity to support that.

b. We will implement the Homelessness step up beds as a discharge route from ED to avoid admission

c. The virtual ward teams at para 33d are managing people away from conveyance to remove the risk of admission and pressure on the discharge pathways

d. The Home First MDT looks at all points to divert people from Pathway 1 to 0 with voluntary sector support. Both inputs are funded from BCF.

e. We are piloting an approach where we use extra care housing pathway flats with integrated reablement to support people on “complex P1”. This may be because of housing issues, or because of specific social/family factors where there may be a risk of reducing independence from diverting to P2.

f. We have reviewed our Pathway 2 model via nursing home short stay hub beds: we are moving to reduce the LoS in these beds from 21 to 10-14 days to improve throughput and to get people home more quickly. Led by the Pathway 2 hub MDT, the new model will increase therapy leadership both in terms of capacity (7 day working) and intensity and will work with nursing home staff who will employ therapy assistants and with GP practices providing medical cover. We will also pilot the use of assistive technology to support this discharge, introducing the kit in P2 to improve confidence and therefore compliance on return home. These initiatives are funded by BCF.

g. The short stay hub beds also manage people who may be for long-term P3 (e.g., CHC discharge to assess). We will be developing our model for D2A for more complex care e.g. in cases of delirium where we need to manage the risk of a pre-emptive referral into P3

h. In developing our support to care homes we will also be seeking to use this resource to support the safe and timely discharge of people with mental health needs especially where they are returning to their usual place of residence. We will also use this input to support discharges from secure mental health settings of older adults with dementia and other presentations.

i. We continue to commission from the BCF pool in partnership with District councils a dedicated discharge pathway for homeless people.

j. We will fund additional discharge liaison capacity over winter especially to support discharge of children and young people; people in surgical wards who

may be able to discharge home on Pathway 0; discharge of people from outside of Oxfordshire.

k. We will implement a Trusted Assessor model jointly with partners from OACP and OCHA to enable care providers to safely and with confidence take referrals and returners in need of long-term care

40. These actions will support the delivery of metric 8.4 which was agreed by Oxfordshire Improvement Leadership Board at its meeting on 13 September 2022. OILB will monitor and assure delivery of this trajectory.

a. **Metric 8.3**. Oxfordshire is challenged around delivery of this metric as set out above, but we have retained our 21/22 target. The schemes set out above will support greater flow home and as a system we are committed to delivery.

b. **Metric 8.4**. As above para 31b.

| | | 19/20 | 20/21 | 21/22 | 22/23 | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Actual | Actual | Actual | **Annual Plan** | Q1 | | Q2 | | Q3 | | Q4 | |
| | | | | | | Plan | Actual | Plan | Actual | Plan | Actual | Plan | Actual |
| 3 | % of people who are discharged from acute hospital to their normal place of residence | 91.3 | 90.3 | 91.5 | **93%** | 93% | 90.5% | 93% | | 93% | | 93% | |
| 4 | Long term support needs of older people met by admission to residential and nursing care homes per 100,000 population | 597 | 442 | 370 | **352** | 85 | 67 | 170 | | 261 | | 352 | |

## Supporting unpaid carers

41. The BCF funds the Oxfordshire Carers Support Service which provides advice, assistance, and practical support. This is commissioned by the Council on behalf of the ICB. The Service distributes grants on behalf of the Council and the NHS and is joint funded from the NHS minimum contribution.

42. In 2021/22 the national Carers Survey raised some significant concerns around our support for Carers, and we have co-produced a response which includes services funded additionally from the BCF from 2022-23:

a. An expansion of the existing Dementia Support Service

b. The development of a parallel service for people with mild cognitive impairment but whose needs are impacting on the unpaid carers ability to manage and support their loved one

c. Increased dementia education and information for carers

d. Increased practical support for carers across all domains: respite for shopping or social activities that reduce isolation and carer stress; practical support re travel, minor items of household and garden maintenance.

e. This increased practical support will be backed by a mapping exercise carried out with Carers groups to identify gaps and the extent of the need to inform our commissioning approach from the BCF from 2023/24

### Disabled Facilities Grant (DFG) and wider services

43. The DFG is passed through to the District Councils for deployment. The BCF funds Home Improvement Agency to enable the implementation of the DFG and

support the continued independence of vulnerable people within their own communities.

44. Oxfordshire County Council has a Deputy Director, Housing function and dedicated team integrated within Adult Social Care. This team supports the interface with District Councils in terms of planning approaches and housing development (especially supported living and extra care housing) and manages the relationship with the Districts around homelessness. This capability has informed and facilitated the development of the various homelessness and extra care housing initiatives set out in this Plan

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

46. During 2022/23 we will develop this work into a view of the inter-relation between care costs (health and social care), housing (tenancy) costs, equipment and adaptation costs to determine whether there is (for instance) the opportunity to create more bespoke and personalised packages but also how we can align the health and care needs identified in Oxfordshire Way strengths-based assessment or anticipatory care planning with housing and adaptation. We have identified several lines of enquiry

    a. Whether we can pool resources arising from high-cost care and equipment packages with adaptation costs to create a more personalised, effective and efficient package for people with complex needs. This may involve using BCF to fund additional specialist therapy assessment to support care planning
    b. The role of District Councils' and housing providers in identifying and managing falls risk
    c. Rethinking our approach to extra care housing in terms of allocation thresholds and in-reach support
    d. Ensuring that we have an equitable offer across the County between the different districts and using the BCF from 2023-24 to support that

## Equality and health inequalities

**47.** We have completed an Equality and Climate Impact Assessment to support the Better Care Fund Plan, and this will be reviewed in Q4 2022/23 especially in relation to an improved understanding of the impact of our performance on BCF metrics in relation to protected characteristics.

48. The Oxfordshire JSNA has identified both geographical populations (in parts of Banbury and Oxford) and areas of need where Oxfordshire does worse than baseline, especially in relation to younger people and older people, where prevalence of depression, loneliness and admission to hospital owing to falls are

above average and the dementia diagnosis rate is below. These findings have led the BCF in terms of

a. The approach to implementing the Oxfordshire Way and in particular the priorities for the Community Capacity grants programme to support social prescribing and address health inequalities
b. Our focus on falls within this Plan where Oxfordshire is an outlier and within Oxfordshire where there are particular hot spots across the County

49. A review of performance across the BCF for 2021/22 identified key areas of inequality

a. The needs of people especially children and young people in acute hospital settings around mental health. We have invested additional resource from the BCF to support people in ED
b. The needs of carers as set out above at para 39
c. The needs of homeless people, especially in relation to attendance at ED as set out above
d. A gap in our pathways to support older people with delirium in our discharge pathways
e. The need to support people especially around physical activity which is reflected in the prevention elements of this Plan

50. In developing the BCF Plan for 2022-23 we have mapped in longer-term projects that will need to be built into the plan from 2023-24 in line with the intended BCF 2-year planning cycle. These areas include are key system challenges around equality

a. **Homelessness**: funding for the current range of services is due for review in 2023.
b. **Children and Young People**: development of dedicated accommodation and support to divert children on neuro-divergent pathways to avoid the need to admit to hospital, bring them back into County from out of area placement
c. **Learning disability and/or autism**: development of step up and down supported housing pathways that bring people back in County and reduce need for general or specialist hospital admissions or high cost out of area placement
d. **Housing**: funding for *Better Housing, Better Health* ends 2023 which is a Public Health and District council led initiative to support people with poor housing and in fuel poverty
e. **Housing support for people with complex needs**; need to increase accessibility, coverage, and impact of our use of adaptations and technology to enable people to live independently at home
f. **Prevention**: future funding of Move Together exercise model, and consolidation of social prescribing and community capacity in line with Oxfordshire Way around health inequalities