NHS
Oxfordshire
Clinical Commissioning Group

Health Overview and Scrutiny Meeting: Better care Fund Update
17 September 2015

1.0 Introduction

The BCF Plan was approved by the Oxfordshire Health and Well-being Board (HWB) on 09 January 2015 following a lengthy stakeholder engagement process. It is an ambitious program, made up of 12 individual projects that aim to support the local health and social care economy embedded in principles of integration and joint service delivery.

In an effort to ensure successful implementation and delivery of overall BCF Programme, Oxfordshire has put in place strong local governance arrangements. These arrangements aim to provide system wide leadership to the constituent parts of the programme as well as adequate scrutiny to allow the achievement of the 2% reduction in NELs based on the 2013-14 activity level, as per our original submissions.

The ultimate responsibility for the successful delivery of the programme lies with the Health and Wellbeing Board (HWB) and the System Resilience Group (SRG). There is a well-established BCF Programme Board, which meets every 6 weeks with a membership representing all stakeholders, including NHS England. The Board is chaired by the Director of Delivery and Localities.

2.0 Overall Progress

The Oxfordshire system has continued to implement and embed the original principles that the BCF was founded upon. There have been many successes over the last quarter with regards to the implementation of some of component projects with some preliminary data coming across. The system has collectively been working towards dealing with the challenges within the system through aligning the requirements of the BCF with other strategic priorities, most notably the Older Peoples Outcomes Based Contract (OBC).
We have continued to see progress in terms of a system change to deliver an integrated, coordinated and preventative health and social care system especially for patients with complex and changing needs.

The Digital Proactive Care Plan (dPCP), that was under development as part of the Oxfordshire Care Summary, is now operational and includes all of the mandatory care elements from the range of care planning forms available in Oxfordshire (including Oxfordshire Urgent Care Service Handover form, Special Patient Notes, Advanced Care Planning, Anticipatory Care Discussion form for Patients without capacity, Anticipatory Care Plan for Hospitalisation form and Unplanned Admissions Enhanced Service Care Plan). As of

the 31 July 2015 50% of care plans produced by GPs in primary care for patients within 2% of their population who are thought to be at high risk of admission were established in the digital format (dPCP). As of 31st July 2015 the new view of Oxfordshire Care Summary presents digital care summary information to view on systems for A&E, OOH, 111/SCAS.

We continue to increase the number of care homes that receive Proactive Medical Support, and have identified and are supporting the top 2% of the population most at risk of an emergency admission.

Integrated Locality Teams continue to be developed and embedded into the local health and care pathways; They also:

- Continue to test different models of co-location which will be evaluated 3 months after go live to understand where the added value is to the change in practice and outcomes for staff and patient
- In the south-east locality the health and social care leads have started to work with 2 practices to test out how a single care plan 'for the most vulnerable and at risk of admission patients' can be developed and delivered together – the first practice outputs will be evaluated in October and the second in November before rolling out an agreed tested model in the new year.
- Personal care planning training – the integrated teams are part of the Thames Valley Year of Care Training plan, with Oxfordshire having 5 qualified trainers by the end of the year. Training of the personal care planning approach is starting in the two south localities in November with unregistered and newly qualified staff.
- Circle of support – this national pilot delivered by Age UK and part of the six locality teams has a local extension of funding until April 2016, with the national evaluation is due in December

In line with the BCF Programme, the Oxfordshire system continues to work with providers to develop Ambulatory Care Pathways, including Emergency Multidisciplinary Units(EMUs). The system has joined the Ambulatory Emergency Care Network to develop this area of important work further. This is in line with national and local agenda to treat patients in an ambulatory way where possible and appropriate. There are generic pathways for patients with ambulatory conditions and their progress through the system is subject to a current review, as is the progress and impact of the EMUs on the patient journey.

Care Act reforms implemented from April 2015 are now bedding in, and we are meeting all statutory requirements. The new assessment and support planning process for carers is working well, with around 70% completing online self-assessments. The process is being

reviewed on an ongoing basis, and some minor changes were made to ensure that needs were being accurately captured and reflected in resource allocation.

Help to Live at Home continues to be on track to deliver a new model of home care, with tender documentation due to be issued 1st September. The Information and Advice Strategy is currently out to consultation, proposing a new model of provision that moves away from individual funding streams and towards a more coordinated, countywide offering.

The Workforce Strategy for Adult Social Care is being picked up regionally as a model of good practice, and focus is now on establishing appropriate governance arrangements to oversee implementation. Discussions are ongoing about how to develop an overall strategy for workforce across health and social care in the County.

1. Primary Care supported through the Prime Minister Challenge Fund has continued successfully with the implementation of services, and some of the updates include:
    - **Oxfed (Oxford City GP Federation):** Operations Manager has successfully been recruited who will be supporting the lead GPs in the project mobilisation work. Practice Care Navigators - OxFed are working closely with Age UK and the Care Navigators have now been recruited and currently inducting.
    - Practice Visiting Nurses - The lead advanced nurse practitioner and the visiting team posts are now out to advert. OxFed have received advice and support from Oxford Health who provide the local Community Nursing Service. Secondment opportunities are being offered to Oxford Health community nursing staff, ensuring strong collaborative working, a joint strategic approach and an opportunity to share learning.
    - Shared records for out of hours (OOH)-: the providers of the Out of hours service have been receptive to plans and their IT department is working with OxFed and EMIS to ensure the technical solution can be implemented as soon as possible.
    - **PML:** The Early Visiting Team pilots for North and North East Oxfordshire have been successfully rolled out, with two more teams to follow. From 1st June to 10 July the teams undertook 138 visits. Feedback from practices has been very positive.
    - **Abingdon:** E-consultations was up and running at the end of last month. There have been some technical issues in the first couple of weeks (not unexpected). EMIS Anywhere terminals and EMIS mobile software is to be deployed so that GPs can deal with patients remotely including doing EPS prescriptions.
    - **Online health resource:** an online health resource, County of Oxfordshire Advice on Care and Health (COACH), is being created by the Abingdon Federation for

eventual use by all Oxfordshire Federations. This design work is well underway with strong patient and stakeholder engagement.

3.0 Conclusion

The BCF plan is an ambitious set of projects which have the potential to provide more appropriate care for Oxfordshire residents and in doing so address enduring problems such as reducing delayed transfers of care and contribute to consistently achieving the reduction by 2% in the number of non-elective admissions target the system has set for itself.

The plan also aims to address the increasing demand for urgent and emergency care posed by demographic change in over 65s, which is growing at an annual rate of 1% per year. The impact of this growth is an average 4.3% growth a year in demand for non-elective admissions. Reaching a 2% reduction overall therefore compensates for growth and a further reduction to reach the 2% target.