# Health Overview and Scrutiny Meeting

Thursday 22nd April 2021

- ***Diane Hedges*** *Deputy Chief Executive*
  *Oxfordshire Clinical Commissioning Group*
- ***Dr Ben Riley*** *Executive Managing Director for Primary Care and Community Services, Oxford Health NHS Foundation Trust*
- ***Stephen Chandler*** *Corporate Director of Adult and Housing Services, Cherwell District Council, Oxfordshire County Council*

# Oxfordshire Community Service Strategy: update for HOSC April 2021

- Resolution for OX12 and Wantage community hospital
- Design and improve community services provision
- Maximising independence and interdependence for people in Oxfordshire
  - A strategic approach supported by the Health and Well Being Board March 2021
- Developing approaches through engagement and active learning

# Maximising Independence in Oxfordshire Residents

As part of our Community Services strategy, we are developing new approaches to improving community services in Oxfordshire for people at all stages of life – Start Well, Live Well and Age Well.

The Health and Well Being Board Older Persons Strategy sought to support our older people in **Living Longer, Living Better** identifying some key actions to do this

Mandate for action on the life stage of Age Well:

- Increasing independence and health and wellbeing outcomes for our population
- Working with our population to make best use of our people, our systems and our assets

Approval given from Oxfordshire Health & Wellbeing Board for a system-wide strategic approach to deliver these above outcomes

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South Oxfordshire District Council Listening Learning Leading

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# Wantage Community Hospital and OX12 project

Factors identified in the OX12 project that need to be addressed included:

**Certainty on the inpatient beds and enhancing the model for rehabilitation**

**Travel and access to services** **Healthy living** **Addressing Loneliness**

To address these issues we are proposing a whole system strategy for both health, care and daily living. Very significantly our **learning from COVID has shown** how much more we deliver together in partnership with Councils, Local stakeholders and in working in new ways.

Expanding our thinking to **maximise independence** and **best deployment of assets (staff, money and estate)** we will address the OX12 considerations. We will review the function, numbers and professional skill mix of the community inpatient provision required for the county, addressing the factors found in the OX12 work and also informing our approach for those people who need specialist rehabilitation only possible in an inpatient (bedded) setting.

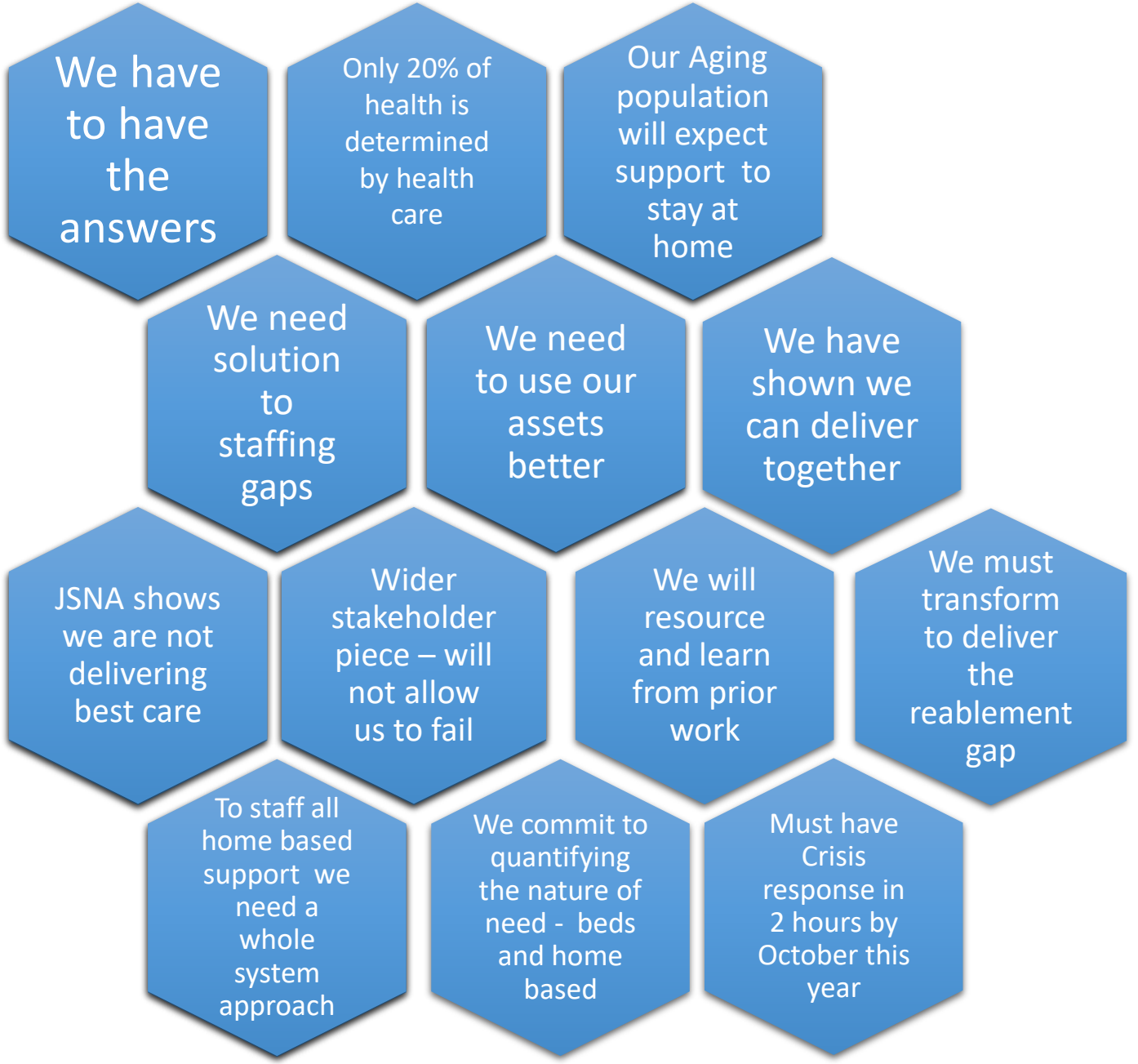
The system-wide Community Services Strategy project will work to address answers for OX12 by taking the very significant learning from the pandemic and optimise ways to enable independence for our residents and will be informed through public engagement and where substantial change is indicated full consultation.

Wantage Community Hospital will play a key role in supporting any new integrated model.

# Reflections

- We recognise that there has been a long delay in providing local residents with a firm conclusion for the future of the Wantage Hospital inpatient rehabilitation unit and for progressing the outcomes of the OX12 project more broadly.
- It is important that OX12 residents get certainty of service provision and can have confidence in their access to effective rehabilitation whether in beds or at home and how this is equitable
- The National Level 4 incident announced 3 March 2020 required a total NHS and Care focus on managing COVID
- Despite unprecedented challenges this winter, important work has progressed. A summary is given in the HOSC substantial change toolkit document.
- A range of services have also been re-established at Wantage Community Hospital, following the building work to address the Legionella risk, including the re-opening of the maternity/birthing unit and the provision of local services such as podiatry, community therapy and school nursing. Plans are in development with partners to pilot consultant-led outpatients and mental health services from the hospital
- The NHS System **MUST** deliver the Operational and Planning Priorities for 2021/22 – there is synergy with getting the answers for OX12, linking Primary Care Networks, Local stakeholders and delivering better services for all. These Planning priorities will guide our approach
- The strategy will be shaped by the ambitions set out within the NHS Long term plan and the Oxfordshire Joint Health and Wellbeing Strategy and will reflect the need to ensure community services are sustainable
- The COVID risk continues and we remain at a Level 3 incident. When this moves to Level 2 we commit to progression of the planning and engagement work as a priority. The pace at which we can progress will be subject to COVID staying at Level 2 but we need to assure residents we will reach a clear resolution soon
- The strategy will address gaps in best care, guide effective solutions on a broader landscape and result in a decision about community hospital beds in Wantage

# Why different this time? Why will it deliver?



# Development and implementation timetable

| Month | Set up and Engagement and External dependencies |
|---|---|
| **COVID period** | Piloted in OX12 the first 2-hour crisis response rolling out the learning to other areas of the county<br><br>Piloted alternative ways to support people – Examples include Home First project and system response, Hotel model and beds solution for plus size people, remote monitoring in peoples own home - such as pulse oximetry to see if a person is deteriorating with COVID<br><br>New ways of working will continue to be tested throughout the programme in a Pilot and test and learn approach |
| **March 2021** | Mandate approved with involvement agreed from County and all Districts and City as part of Oxfordshire Health & Well-being Board |
| **April 2021** | Oxfordshire A and E Delivery Board urgent care work defined and set alongside to ensure completeness<br><br>Community Strategy described in terms of how it resolves outstanding beds questions for Oxfordshire JHOSC |
| **May 2021** | Engage Primary Care Networks and District/City Council network to determine how we will engage and learn from our residents and recent partnership COVID experience to deliver the changes we need<br><br>Establish engagement working group, looking at existing evidence work and determining further gaps in knowledge and how these will be addressed taking approach to the June HWBB |
| **June 2021** | Programme authorised by Oxfordshire Health & Wellbeing Board Programme with plan and required deliverables finalised<br><br>Programme plan and engagement plan presented to HOSC for review and comment |

Subsequent programme milestones subject to step down to NHS COVID Level 2 and remining at that level

Some dependent programmes will continue at COVID Level 3 where critical to delivering direct care

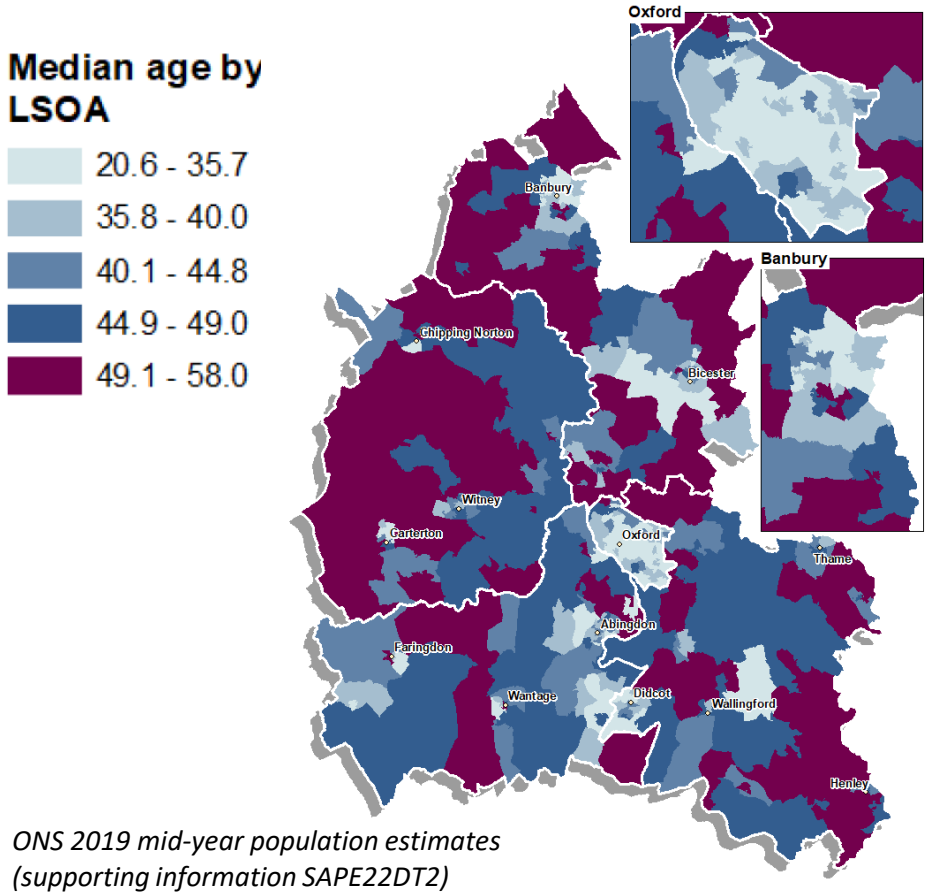
| Month | Programme actions | Additional actions required where a substantial change to service delivery could be impacted on a permanent basis (eg OX12) | Timescale/ dependency |
|---|---|---|---|
| 1 | Confirming a Knowledge Base;<br>• Oxfordshire system wide data to be brought together (giving demand and capacity mapped and compared with the need for care, housing & population growth)<br>• Engagement programme to help draw together and inform experience and priorities<br>Developing a whole Oxfordshire system approach to strength based approach for our residents using engaged approaches in the system to maximise independence and community interdependence | Agree potential areas of substantial change – (to include OX12) | Update and reporting to JHOSC to be agreed |
| 2 | | | |
| 3 | | | |
| 4 | Share learning from our work and how it informs future planning using the knowledge base and develop new ways of working across the system | Additional targeted engagement (some before and then concurrent with Option development) | |
| 5 | | Options – overall process, stakeholder event(s), agree criteria and develop options<br>Recommendations to HWBB, ICS, Oxfordshire System Partnerships and review with JHOSC | (4 months) subject to relevant organisation sign off |
| 6 | Oxfordshire system wide review and agreement on model for maximising independence and community interdependence (excluding any substantial service change requiring consultation) | | |
| 7 | | Preparation of Pre – consultation business case including evaluation of pre business case models | (up to 2 months – assumes some overlap with above) |
| 8 | | CCG Board approval of Pre – consultation business case | CCG Meeting in Public |
| 9 | Phased implementation of new model begins where agreed by system (excluding any substantial service change requiring consultation). Successful pilot work developed into business as usual | NHSEI Assurance process to include Clinical Senate support (can run concurrently with consultation preparation but must be successfully concluded before consultation launch) | (estd 3 months)<br>NHSE and clinical senate support |
| 10 | | | |
| 11 | | Preparation of consultation materials and resources | (1 month/6week) |
| 12 | | Formal public consultation | (up to 3 months)<br>CCG Meeting in Public |
| 15 | | Consultation review and write up – share with Partnerships | (up to 2 months) |
| 17 | Oxfordshire system approach known including any substantial change | Final Business case to CCG/ICS Board for Decision | CCG Meeting in Public |

# Building on what we know

- Key lessons from the JSNA and quality standards we need to deliver
- Community health services

# JSNA 2021 – themes for older people

In 2019, older people aged 65+ made up 20% of the estimated population of Oxfordshire's four rural districts, compared with 12% of the population of Oxford City.

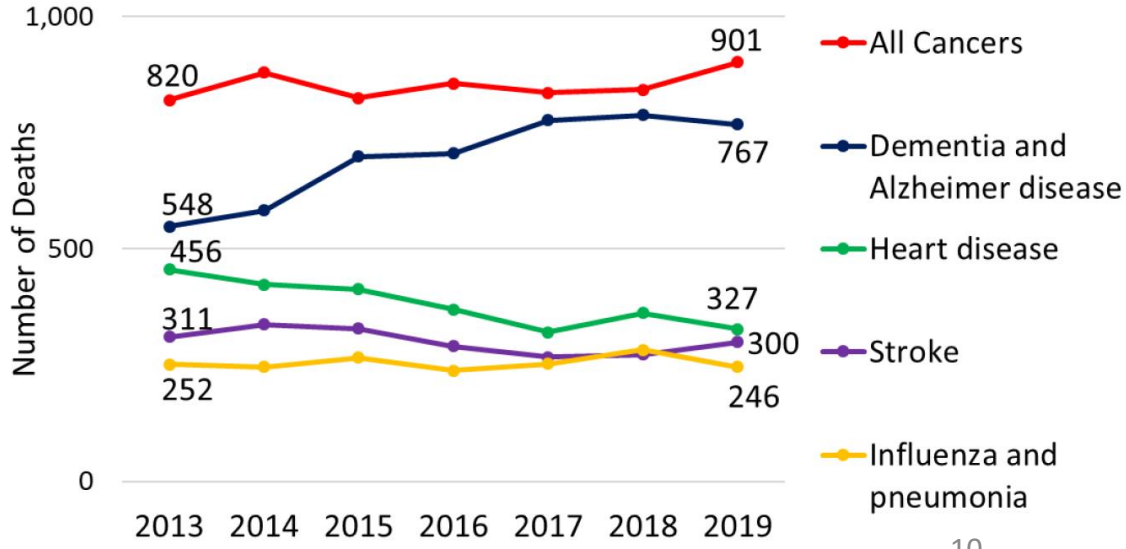



*ONS 2019 mid-year population estimates (supporting information SAPE22DT2)*

Four health conditions in Oxfordshire were above the England average 2019-20:

- Cancer
- Cardiovascular disease
- Depression
- Osteoporosis

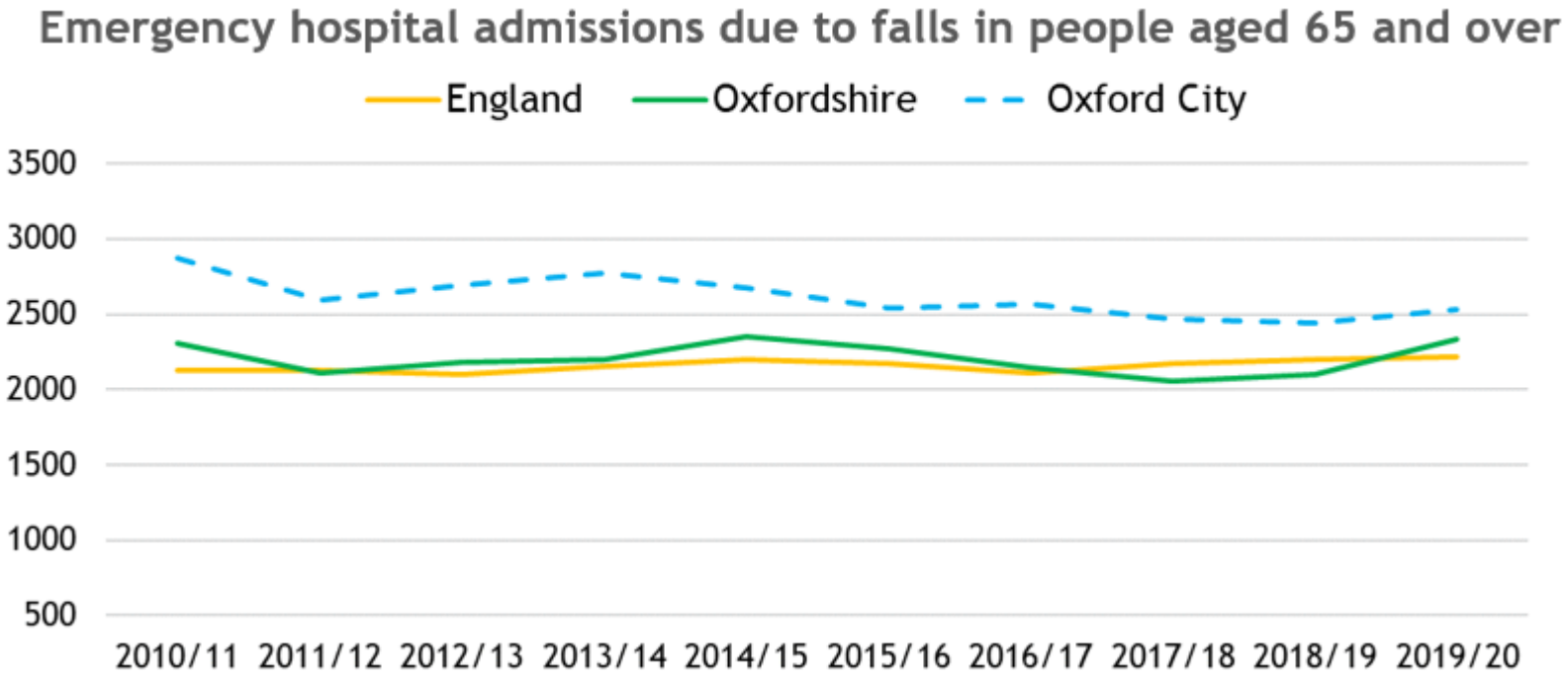
Leading causes of death for those aged 75+ in Oxfordshire:



# Hospital admissions due to falls

Falls are the largest cause of emergency hospital admissions for older people. In 2019/20 there were 3,165 hospital admissions due to falls in people aged 65 and over in Oxfordshire. This rate is higher than national rate (2,331 per 100,00 population in Oxon compared to 2,222 in England).

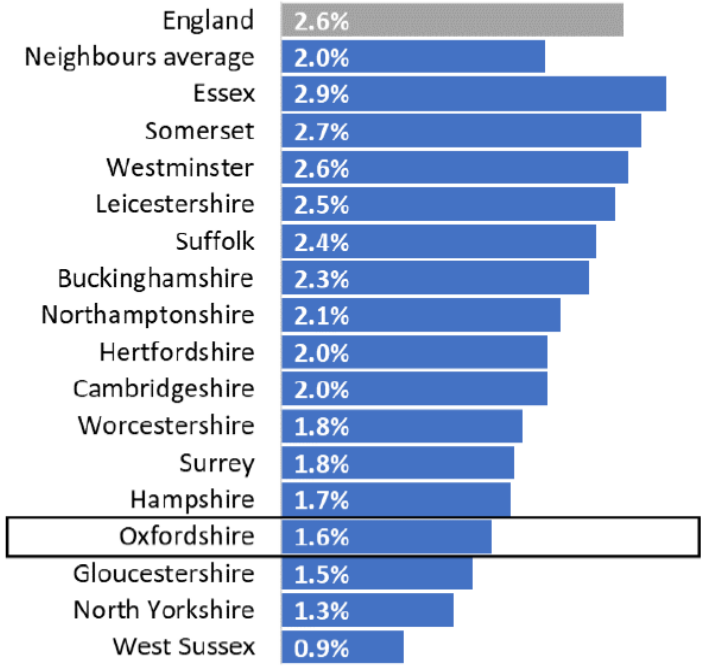
The five district areas in Oxfordshire have similar counts of hospital admissions (500-800 per district), however over the last ten years, the rate has been consistently higher in Oxford City.



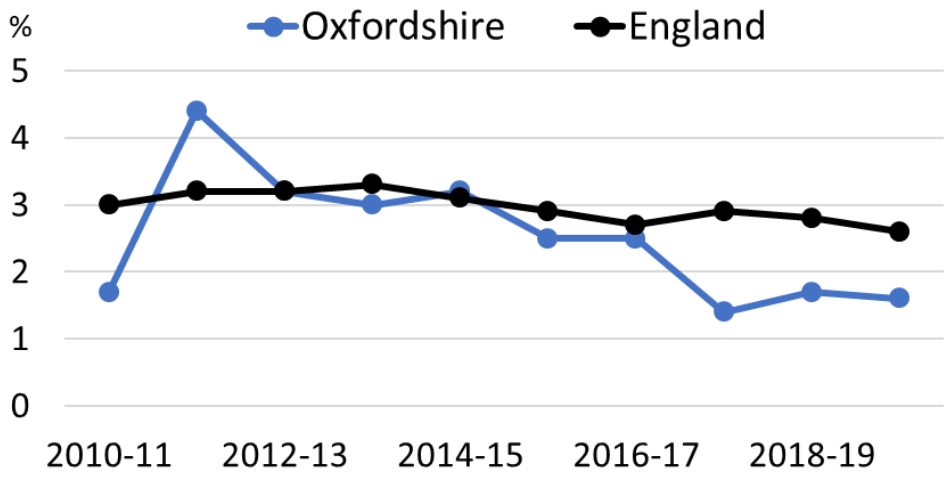

| Indicator | Period | Oxon | | | Region England | England | England | | |
|---|---|---|---|---|---|---|---|---|---|
| | | Recent Trend | Count | Value | Value | Value | Worst/ Lowest | Range | Best/ Highest |
| Emergency hospital admissions due to falls in people aged 65 and over | 2019/20 | → | 3,165 | 2,331 | 2326 | 2222 | 3,394 | | 1,325 |
| Emergency hospital admissions due to falls in people aged 65-79 | 2019/20 | → | 975 | 1,074 | 1049 | 1042 | 1,847 | | 627 |
| Emergency hospital admissions due to falls in people aged 80+ | 2019/20 | → | 2,185 | 5,977 | 6029 | 5644 | 8,227 | | 3,348 |

# Reablement services

Between April 2019 and March 2020, 2,601 people in Oxfordshire received reablement. Of these, 1,461 were helped to leave hospital, 366 were diverted from hospital and 774 were supported via a community referral. As of 2019-20, Oxfordshire was ranked 13th in its group of 16 statistical neighbours on the % of older people offered reablement services following discharge from hospital. Oxfordshire has remained below the national average.




*Percentage of people aged 65 and over offered reablement services following discharge from hospital, Oxfordshire and Statistical Neighbours (2019-20)*




*Percentage of people aged 65 and over offered reablement services following discharge from hospital – trend*

# Isolation

Isolation and loneliness have been found to be a significant health risk and a cause of increased use of health services. From Age UK's 2015 loneliness analysis, the following areas are in the highest risk quintile of all neighbourhoods in England:

- Cherwell: Banbury, Bicester Town
- Oxford: Blackbird Leys, Wood Farm,
- Barton, St Clements, Jericho, Cowley
- South Oxfordshire: Didcot South

Isolation in older people is exacerbated by sight loss

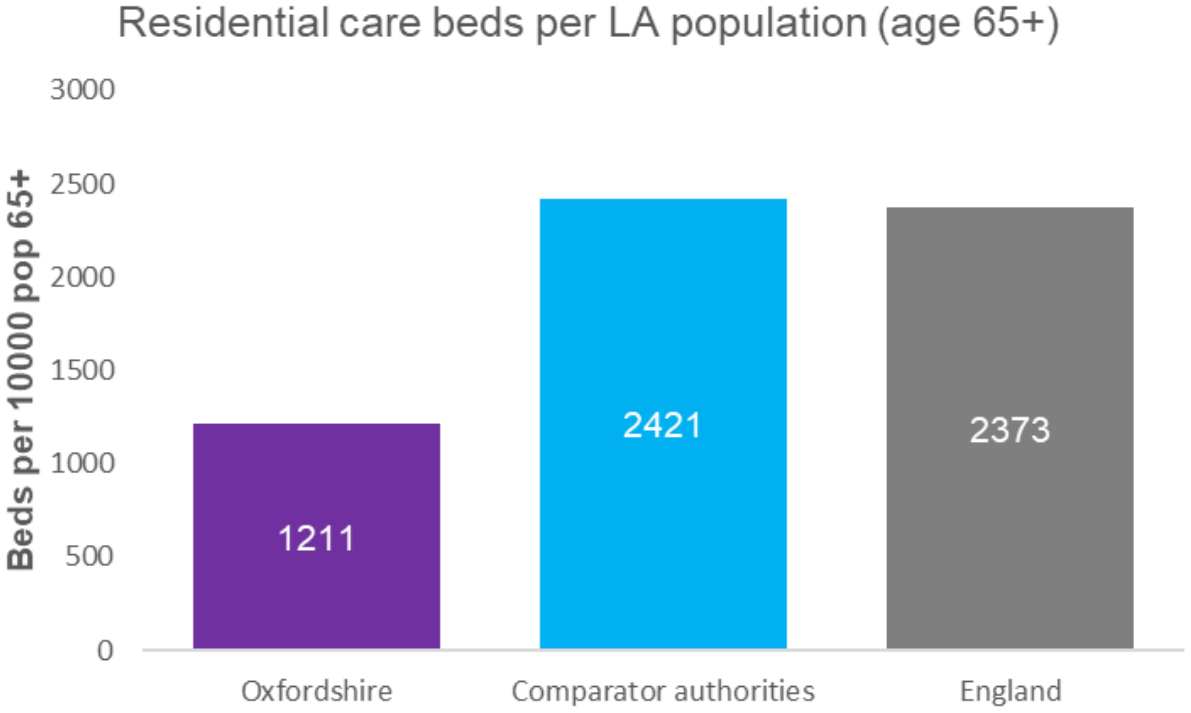
*Sight Loss: Number of people estimated to be living with sight loss in Oxfordshire (2016 and future estimates to 2030)*

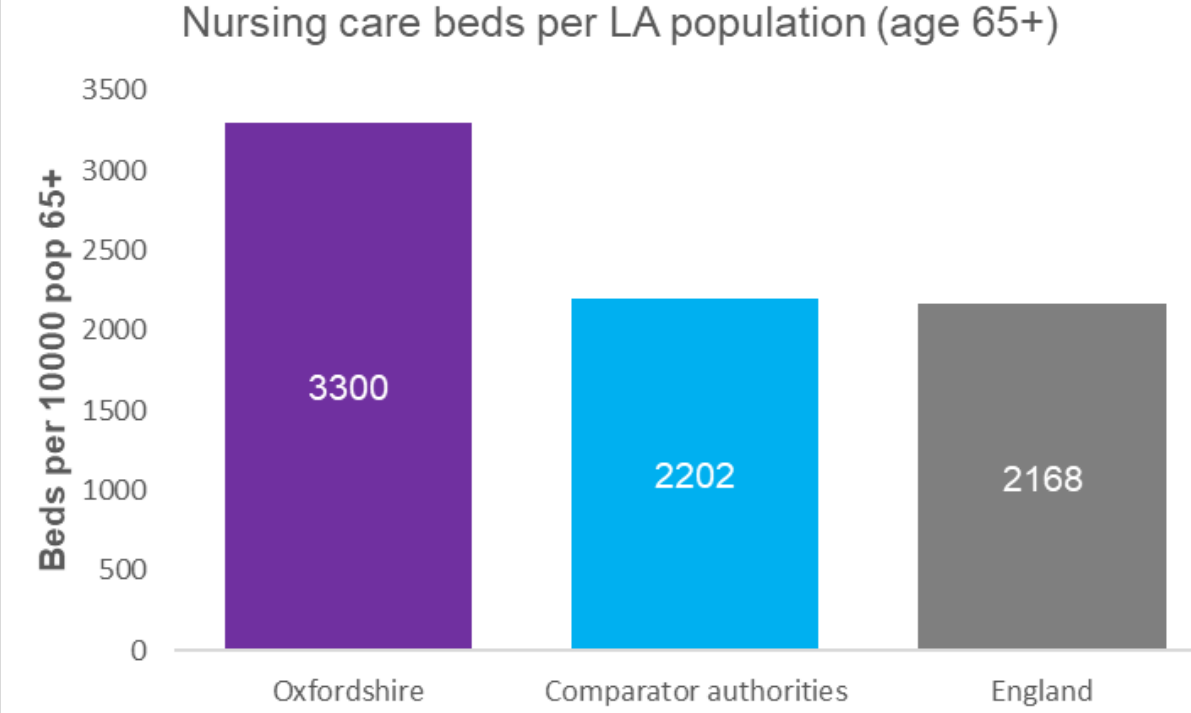
| | 2016 | 2020 | 2025 | 2030 |
|---|---|---|---|---|
| Mild | 13,630 | 15,050 | 17,090 | 19,560 |
| Moderate sight loss | 4,690 | 5,160 | 5,800 | 6,570 |
| Severe sight loss | 2,800 | 3,130 | 3,620 | 4,200 |
| Total | 21,110 | 23,340 | 26,510 | 30,330 |

| Indicator | Period | Oxon | | | Region | England | England | | |
|---|---|---|---|---|---|---|---|---|---|
| | | Recent Trend | Count | Value | Value | Value | Worst/ Lowest | Range | Best/ Highest |
| Social Isolation: percentage of adult social care users who have as much social contact as they would like (65+ yrs) | 2019/20 | ➡ | 1,425 | 39.1% | 42.9% | 43.4% | 30.4% | | 53.8% |
| Social Isolation: percentage of adult carers who have as much social contact as they would like (65+ yrs) | 2018/19 | – | 110 | 30.3% | 32.7% | 34.5% | 11.1% | | 50.9% |

There is huge potential to address this with all partners and particularly the Voluntary Sector. This will build on some important work already underway and our learning from COVID partnerships

# Long term care - Oxfordshire has 50% higher number of nursing home beds




Source: CQC registered care home beds April 2021; ONS 2019 population estimates

# How we use long term care

We support more people in long term bed based care than similar authorities; 45% are supported in care homes compared to 40% nationally.  Equally we place significantly more people in nursing home care

Rate per 10,000 people supported:

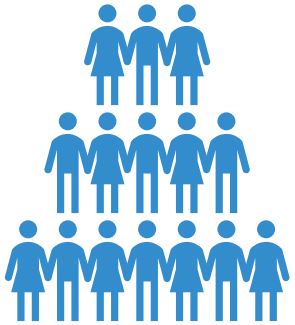
| | 65+ |
|---|---|
| Oxfordshire | 472.6 |
| England | 608.7 |
| Similar Authorities | 479.0 |

% of older people supported by care type:

| | Residential care | Nursing home care | At home |
|---|---|---|---|
| Oxfordshire | 22% | 23% | 55% |
| England | 27% | 13% | 60% |
| Similar Authorities | 29% | 14% | 57% |

# Oxford Health Foundation Trust Community Services

Over **2000** staff



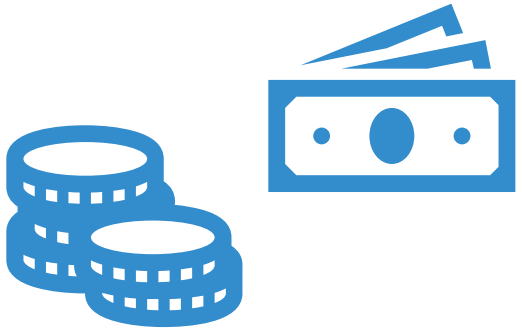
**9** community hospitals

Deliver services from over **75** sites and people's homes

**1,350** admissions to community wards

Over **680,000** appointments per year

**£97.8m** annual budget



*Data as at financial year 2019/20*

## Action we need to take

- Collective approach across Oxfordshire

# Maximising Independence in Oxfordshire Residents

As part of our Community Services strategy, we are developing new approaches to improving community services in Oxfordshire for people at all stages of life – Starting Well, Living Well and Ageing Well.

The Health and Well Being Board Older Persons Strategy sought to support our older people in **Living Longer, Living Better** identifying some key actions to do this

Mandate for action on the life stage of Ageing Well:

- Increasing independence and health and wellbeing outcomes for our population
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# Independence & better outcomes

**To improve the health, wellbeing, independence and care experiences of individual residents, while strengthening the interdependence of people, families and communities across all of Oxfordshire.**

**What do we mean by independence?**
Enabling individuals to strengthen and draw on their personal capabilities and resources, their social networks, services and communities to live healthier lives and, to the maximum extent possible, take informed actions to improve their health and care.

**What do we mean by interdependence?**
Interdependence recognises the importance and value of mutually supportive social connections, reciprocal relationships and the interactions between the determinants of health and wellbeing, in improving the long-term health of people, families and communities.

# Drivers and Opportunities

- Patient experience
  - When older people cannot access support with independence they are at risk of avoidable harm, whether at home (for example falls) or in beds, and risk deterioration or escalation
- National drivers
  - Hospital Discharge, Oxfordshire needs to increase the proportion of people discharged home with no support  or with reablement support
  - Need to review resources to deliver integrated planned care closer to home and urgent community response when people are at risk of going to hospital
  - NHS Long term plan, more joined-up care and integration of primary and community services
- Opportunities
  - Learning from covid response: integrating community resources that extend the reach of health and social care to support independence
  - Redeploying sites to support more planned and preventative care delivery

**Areas of focus**

***Quality***
*Achieve the best health outcomes and experiences*

***People***
*Be the best possible place to work in community care*

***Sustainability & Partnership***
*Enable people and communities to stay healthy and resilient*

***Research & Training***
*Continuously improve health in our communities*

**Population groups based on key life stages**

**START WELL**

*Improved opportunities and outcomes for Children and Young People – and more effective support for vulnerable families*

Healthy development

Preventative care and safeguarding

Children's nursing and therapy

**LIVE WELL**

*A healthier life for people living with long-term conditions and improved outcomes for people who need unscheduled care*

Health and wellbeing for people with long-term conditions

Anticipatory care and personalised care planning

Effective care for unexpected illness and injury

**AGE WELL**

*Healthier older people able to live independently for longer - with improved experiences for those who need care*

Intensive community care
(step-up / crisis response)

Rehabilitation and recovery
(step-down / complex reablement)

Care towards the end of life

# Approach

- Working with local communities and stakeholders across the system
- Building on learning from Covid and other community engagement
- Identifying opportunities to test and learn pilots that can support co-produced solutions e.g.
  - Rethinking bed-based models of care
  - Exploring which services can be offered from community sites
- For success and delivery in reasonable time frames we need this to be resourced and established within system governance structures

# Engagement approach

## Review what we already know

- Gather existing patient experience & feedback from engagement with patients, carers and families.
- Gather together information from previous engagement; reducing delays; the OX12 project and the Big Conversation and Consultation
- Draw out key themes and insights to support strategy development.

## Engage stakeholders

**Communities and patient groups**
- Focus groups/meetings. Either face to face, if allowed, or virtual small group engagement.

**Patients and families**
- Interview patients and carers/family/visitors.
- Group discussion toolkit – while under COVID restrictions.

**Staff**
- Team meetings and dedicated engagement sessions will be used to explore staff feedback and shape proposals.

**General public**
- Surveys will be used to gather feedback. Healthwatch and local community groups will be asked to help to publicise.
- Local print and broadcast media and social media will be used to raise awareness.
- OCCG and OH websites. Dedicated space made available to host documents and information about the project.

# How will things change to meet these needs?

To meet the needs of our ageing population, we will work with all key partners to Maximise independence through collective action for **Living Longer, Living Better**

| | |
|---|---|
| Improved health & wellbeing | Maximising residents' strengths through joint working with local communities and stakeholders across the system. Building on learning from COVID and community engagement |
| Anticipatory & preventative care | Proactive care for people with long-term conditions and frailty coordinated by locally integrated MDTs; plans to improve health and independence will be supported and actively monitored by PCNs and neighbourhood teams, working collaboratively |
| Urgent Community Response | Developing existing community and primary care visiting services into a more accessible and effective 24/7 response, that provides the right response from the right professional at the right time |
| Intensive Community Care | Expanding our existing ambulatory care services into a more robust, safe and effective alternative to acute hospital admission, tailored for the needs of older and frailer people, operating 365 days a year |
| Community Rehabilitation | Streamlined in- and outpatient care delivered in / supported by Community Hospital Hubs, 7 days a week including: Intensive rehabilitation pathway, Bariatric / Plus-sized care pathway, Stroke rehabilitation pathway, Sub-acute frailty care pathway |

# Pilots being developed

**ANTICIPATORY AND PREVENTATIVE CARE**

Creating community capacity so that people can help themselves as part of the *Oxfordshire Way*

**VIRTUAL WARDS**

GPs and community services supported by acute clinicians to keep people in their own home

**URGENT COMMUNITY RESPONSE**

Rolling out a 2 hour response to people in their home to help them to avoid having to go into hospital

**HOME FIRST**

Reablement and rehabilitation to enable more people to stay at home when their independence is at risk or return home after a stay in hospital

**ENHANCED CARE HOME SUPPORT**

GP and community health collaborating with care home providers to help people stay safe and well in their home

**SPECIALIST REHABILITATION CAPACITY**

Testing streamlined care pathways for specialist rehabilitation such as bariatric care