Oxfordshire
Clinical Commissioning Group

Oxfordshire Health and Wellbeing Board Meeting

Date of Meeting: 14 July 2016	**Paper No:**

Title of Presentation: Better Care Fund Plan 2016-17

Is this paper for	**Discussion**	✓			**Information**	✓

Purpose and Executive Summary (if paper longer than 3 pages):

This paper updates the Health and Wellbeing Board on the development and submission of Oxfordshire's Better Care Fund Plan (BCF) for 2016/17.

As per national advice, the BCF Plan for 2016-16 is submitted as a continuance from 2015-16 building on the learning/ achievements over the year. It aims to provide a year of stability and incremental improvement. Overall, the plan articulates our vision for health and social care services locally within the context of other strategic priorities. Further, it offers the detail on how we plan to meet the national conditions, including;

- Agreement to invest in NHS commissioned out of hospital services, which may include a wide range of services including social care; and
- Agreement on local action plan to reduce delayed transfers of care (DTOC)

- As part of our submission, we have set a target of avoiding **1000** non- elective admissions using 2015-16 data (including expected demographic growth) as the baseline for this BCF target. This mirrors the ambition set out in the OCCG's operational plan 2016/17. At the time of submission we believed that this was both achievable and realistic and in effect cancels out a proportion of the expected activity growth in year. It is notable that since submission admission levels have risen and are being investigated. There are a number of initiatives which are geared to support the 1000 ambition including Ambulatory Care Pathways, improved access to primary and community services, Falls Pathway, EMUs etc.;
- The submission also includes a DTOC Plan for 2016-17, which builds on the learning from the 2015-16 initiative Re-balancing the System and is designed to reduce both the number of people who are delayed in the Oxfordshire system and the length of time patients stay in hospital when medically fit for discharge.
    - The 3.5% target of bed days lost to DTOC equates at current length of stay to a weekly snapshot of 73 patients delayed, which would represent a 50% reduction in our current system figure. As a system Oxfordshire has reviewed where and how we can reduce our weekly delay across the different forms of delay. Our approach builds on the strengths of the

Re-balancing the System initiative

The plan focusses on the following areas:

- Focus on assessment and choice processes that will reduce unnecessarily delays
- Continued grip on daily and weekly operations to ensure that flow is managed and available resources deployed appropriately
- Planning for discharge from the point of admission
- OCCG's operational plan has prioritised the DTOC Plan and investment in resources will be made available that will support the move to a system that can work in equilibrium.

The plan includes a Risk Share Agreement between OCCG and OCC to support the improvement of the county wide DTOC challenge. The agreement is based on OCC investing in a set amount of home care hours over the course of the year. If the Council does not fully meet this commitment and there is an underspend against the Home Support expenditure budget, the Clinical Commissioning Group will recoup in full any underspend up to the value of £2.1m. Further detail and conditions are found on page 26 of the attachment.

The detailed spreadsheet on funding, planned activity and performance standards is available on request and will be placed on the OCCG Website.

The Plan is currently going through national assurance and we expect to hear the outcome of this process imminently.

Financial Implications of Paper:

In order to deliver the outcomes and ambition as articulated below, Oxfordshire is investing the minimum national amount mandated of £40.607m in the BCF Plan, including:

- £4.532m in the form of Disability Facilities Grant, passported through to the District and City Councils.
- £8.2m for protection of Adult Social Care, this is mandated nationally as part of the BCF legal framework.
- £1.318 which previously paid for the Care Act Implementation (including carers).
- Further support to Social Care includes the continuation of the former NHSE Transfer of £10.3m, and other individual initiatives.

Action Required:

The Board is asked to note:

- The BCF Plan Submission;
- That the BCF Plan 2016-17 was submitted on 03 May 2016, through delegated authority from the Health and Wellbeing Board;
- That the plan is still going through the national assurance process.

NHS Outcomes Framework Domains Supported (please delete tick as appropriate)	
✓	Preventing People from Dying Prematurely
✓	Enhancing Quality of Life for People with Long Term Conditions
✓	Helping People to Recover from Episodes of Ill Health or Following Injury
✓	Ensuring that People have a Positive Experience of Care
✓	Treating and Caring for People in a Safe Environment and Protecting them from Avoidable harm

Equality Analysis completed (please delete tick and attach as appropriate)	Yes	No	Not applicable ✓
Outcome of Equality Analysis			

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Oxfordshire Health and Wellbeing Board

2016/17 Better Care Plan Narrative

NHS Oxfordshire Clinical Commissioning Group

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1.0 Introduction

This narrative provides a context and the detail for Oxfordshire's Better Care Plan (BCF) for 2016-17. As per national advice, it builds on our BCF Plan for 2015-16 and aims to provide a year of stability with continued improvements on patient/system outcomes. The plan articulates the our vision for health and social care services locally, correlating the dependencies/relationships between BCF and the other strategic transformation plans; and the evidence/ governance underpinning the BCF Plan 2016-17. Further, it offers the detail on how we plan to;

- Meet the national conditions, including;
  - Agreement to invest in NHS commissioned out of hospital services, which may include a wide range of services including social care; and
  - Agreement on local action plan to reduce delayed transfers of care (DTOC)

In order to deliver the outcomes and ambition as articulated below, Oxfordshire is investing £40.607m in the BCF Plan for 2016-17. £4.532m of it is in the form of Disability Facilities Grant, passported through to the District and City Councils. We continue to invest in Adult Social Care in line with the contribution made last year, including £8.2m for protection of Adult Social Care (uplifted in line with inflation) and £1.318 which previously paid for the Care Act Implementation (including carers). Further support to Social Care includes the continuation of the former NHSE Transfer of £10.3m, and other individual initiatives. In respect to patients that are cross boundary, we are in discussions with Aylesbury Vale and Swindon CCGs to agree how best these patients are supported.

Existing documents/strategies that correspond to any the above will be referenced clearly and are appended as part of the submission.

2.0 Better Care Fund 2016-17

2.1 Context

The Oxfordshire System has a strong history of working together through its Health and Wellbeing Board and pooled budget arrangements. As a system, we have utilised a number of different mechanisms and governance arrangements to support outcomes for patients, including:

- Systems Leadership Group;
- Transformation Board;
- Systems Resilience Group;
- Better Care Fund Programme Board; and
- Joint Management Group.

NHSE representatives attend a number of these strategic Boards, which has increased visibility and improved confidence in the delivery of the BCF schemes. It has also showcased the strong working relationships at system leadership level. This, in our view has allowed the system better develop and share the vision for the local agenda, including oversight of BCF Plans.

The Oxfordshire system has developed its BCF plan as part of a larger and very complex system operating to support transformation. Therefore, the plan is linked to the Transformation Board agenda which has developed a strong case for change and has agreed a Care Closer to Home model and strategy, both of which are submitted as supporting evidence. The strategy sets out our ambition to achieve a step change in developing community based services and reduce demand for hospital care by:

- Developing local systems of care that bring together general practice, community health, social care and the voluntary sector, supported by specialist advice, to proactively manage local population health.
- Integrating care around patients not organisations, promoting self-care and prevention, offering rapid access to community based integrated services for urgent problems and planned care supporting those with long term conditions to stay well longer.
- Engaging partners, front line staff, clinicians and the public in the development of our transformation plans.

Oxfordshire's Transformation Plan will outline new pathways of care and 5 year action plans for:

- Acute and Integrated care (including urgent and emergency, frail older people, long term conditions and sustainable primary care)
- Planned and Specialist Care (and diagnostics)
- Mental Health Services
- Learning Disability Services
- Maternity and Children's Services

The new pathways will describe how we intend to drive transformation to re-shape the system releasing savings for re-investment in services in the community. The footprint for our transformation plan is largely Oxfordshire however we have formed an alliance with Buckinghamshire and Berkshire West (BOB), led by OCCG's Chief Executive, to provide an 'umbrella' transformation plan on a wider footprint for services such as Urgent Care, Ambulance services and workforce planning. Oxfordshire's transformation plan will be aligned with those at a BOB footprint but will describe a more localised footprint sitting below the BOB level plan.

Locally, we feel that there is much to celebrate and be proud of in relation to the progress that has been achieved in implementing/embedding the BCF plan over the

last year. This, we believe, gives us a sound base from which to evolve BCF principles into business as usual, leading to better patient outcomes as part of an integrated system across health and social care. There have been collaborative working arrangements towards achieving BCF targets through a well-attended and robust Programme Board.
Consequently, our BCF Plans for 2016-17 have cross organisational sign up which continues to develop a collaborative system-wide approach to support partners in achieving their ultimate goal of supporting patients within a tight financial envelope.

The plan is aligned to our strategic commissioning plans across the system including the Health and Wellbeing Strategy 2015-19, Oxfordshire Clinical Commissioning Group's (OCCGs) 5 year strategic plan and the OCCG's Operational Plan 2016-17. The plans have been fully been aligned to the operational plans and therefore take account of provider plans also.

2.2 What is different in Oxfordshire's BCF Plan 2016-17?

In the main, our BCF plan for 2016-17 is an improved and better evidenced continuation from last year, and thus aims to further improve performance with incremental changes derived from the results of our programme evaluation findings.

The Plan therefore remains focused on concentrating on parts of the system and care pathways that require further attention to support patient and system requirements. We aim to improve performance in respect of the 95% A&E target through a number of initiatives including an extension of Ambulatory Care Pathways and the use of interface medics to bridge the gap between primary and secondary care. However, unsurprisingly the main area of focus for Oxfordshire has been and will continue to be reducing our enduring record of unacceptable delays in hospital transfer. There is system-wide buy-in to a very ambitious plan to reduce DToCs, based on responding to current system challenges and a longer term set of solutions to achieve system equilibrium based.

As a system, we have agreed to avoid **1000** NEAs based on our growth calculations using 2015-16 data as our baseline as part of the BCF target. This mirrors our ambition as set out in the OCCG's operational plan 2016/17. We believe that this is both achievable and realistic and in effect cancels out a proportion of the expected activity growth in year. There are a number of initiatives which are geared to support this ambition including Ambulatory Care Pathways, improved access to primary and community services. These are explained in more detail below.

2.3 Key successes and challenges from 15/16:

Over the last year, Oxfordshire's BCF Board has overseen a number of comprehensive evaluations as well as other less in-depth reviews to support performance management of the overall Programme targets. Further, the Board was

keen to get schemes to undertake a year-end self-evaluation to support decision making for BCF 2016-17 (please see above the template).

These and other business intelligence methodologies were used to better understand how individual schemes were performing as a result of which some in year changes were made to projects and targets. The continual evaluation of the programme tried to answer the following questions:

- Are we achieving our set BCF targets?
- Are we able to articulate the input from our various different schemes in line with targets?
- Do we have appropriate and robust governance arrangements? and
- Are these the right schemes?

The evaluation and various scheme reviews have found that Oxfordshire has continued to make good progress across the health and social care economy in line with the national BCF requirements, including better integration and more effective personalised services. Some of the overarching achievements over the last year include;

- **Governance**: there are robust governance arrangements in place for both the Programme and the various different composite schemes within it. This has allowed the whole system an opportunity for the management and performance oversight for the BCF Programme. The BCF Governance Chart and TOR are attached below; please note that these will be updated in line with the new BCF Plan.
- **Data Collection and Business Intelligence**: This has been an intense area of work, resulting in the development of a vigorous data gathering and analysis dashboard to allow the BCF Board to track progress and make changes to targets throughout the year where necessary. This approach will be continued and further developed next year.
- **Scheme progress:**
  - **Ambulatory Care (including EMUs):** These projects have made a remarkable impact on reducing (avoiding) non-elective admissions activity. We have had major success in developing and measuring Ambulatory Emergency Care Pathways, which have contributed greatly to the reduction in our overall non-elective admissions. However, difficulties with national coding guidance have meant that the any reduction in non-elective is not reflected within SUS. Representations have been made to NHS England through our BCF Regional Manager, and regular assurance meetings and we are assured that they are aware of this and accept this is a national issue that needs to be resolved. This reduction places us in a very favourable position when benchmarked against other areas.

- **Integrated Neighbourhood Teams:** Our efforts around integration have been recognised nationally and we have successfully bid for monies for project management of a pilot from NHS England. This money has been used to oversee the development of Chipping Norton Out of Hospital Integrated Nursing Pilot as part of our wider locality developments. On-going work in this area looks to further develop locality teams and ensure they provide a timely response to patient needs in the community
- **Primary Care** developments over the last year have meant that patients have better access to GPs in the community and managed to supporting patients though a number of schemes including especially the Early Visiting Service. These services are currently subject to a detailed evaluation and may be included in the BCF at a later date once their success is proven.
- **Adult social care** successfully implementing the Care Act requirements from April 2015, including online self-assessment for carers as part of a redesigned process to identify and meet eligible needs for support.
  We are continuing to meet increased demand for services, including an increased number and complexity of care packages for people remaining in their own home. There are a number of social care measures that are included within the BCF Dashboard and we plan to make these more prominent as part of performance management. We also aim to have DFG related performance measures included within the Dashboard to ensure all the BCF funds are supporting the Programmes overall aims and objectives.

However, we have had a challenging year with increased demand on services, high attendances and low bed capacity. This has reduced the system capacity to move patients from the acute and resulting in lower performance. Further, the acuity of patients attending seems to be higher which has resulted in an increase in the number of patients breaching four hours.

- **NEAs:** It is fair to say that we are unlikely to achieve the 2% NEL admissions target set for Oxfordshire. Please note that this was a net reduction on 2013-14 baselines without taking account of expected growth. There are a number of reasons for this, including; increased demand from older patients who present with increased levels of acuity; difficulties with recruiting & retaining staff; and financial challenges within health and care. However, when achievements from our Ambulatory Care Project are taken into account, we are doing favorably against national benchmarks.
- **DToC:** Oxfordshire has continued to struggle with reducing the level of patients delayed in an acute setting, which in turn has an impact on the rest of the system. It is assumed that the DToC plan will resolve this longstanding issue within the local system; however, there is still an ongoing risk.
- **Progress against plan:** The whole system has been challenged through an increase in demand for services from an ageing and increasingly complex demographic. At month 11, the system is 0.1% above the target set for BCF

last year. Although this is disappointing, it means that we have avoided any growth in the system.

Taking account of our successes, challenges and areas for further concentration BCF Board has agree on the following schemes to be included in the Plan for 2016-17:

1. Ambulatory Emergency Care including Emergency Multi-Disciplinary Units (EMUs)
2. Long Term Conditions (LTC)
3. Enhanced Medical Support to Care Homes
4. Falls Pathway
5. Re-ablement Pathway
6. Supported Hospital Discharge Service
7. End of Life
8. Oxfordshire Care Summary - IT Enabler
9. Adult Social Care Schemes (listed in the Planning Submission).

These schemes are subject to Project Management Governance arrangements from within their perspective organisations (mainly supported by OCCG), reporting to the BCF Board on regular basis.

2.4 Changes from the 15/16 BCF plan including rationale/evidence supporting the changes

As mentioned above our BCF Plan for 2016-17 in the main aims to deliver improvements included within last year's plans which are strengthened, based on the outcomes from this year. This allows the system a year of stability whilst ensuring that we have the ability to embed transformational change leading to better integration of services across the system.

We are proposing to continue with established governance arrangements through existing structures, including the BCF Board, with the Health and Wellbeing Board providing the ultimate guidance and leadership. We also propose to continue to develop our data gathering and monitoring arrangements in place for the Programme which we believe provide, through the Board, a robust assurance for the system overall that progress is driven through an evidence base allowing an on-going circle of evaluation. This allows for the system to intervene and take action when challenges are identified on a timely basis.

However, based on our performance and system challenges, we have made some changes to the schemes included in the BCF 2016-17. These are areas that require further work and attention and we believe allow incremental improvements in addition to the ones in the system already. The following are changes from last year's BCF Plans:

1. **Ambulatory Care Pathways (including EMU)**: We are currently in the process of developing further modelling for these services; however we

expect the changes planned within the year will allow a reduction of around 500+ NEAs avoided.

This is an exciting programme of work which has proven to make a difference to patient outcomes while reducing non-elective admissions over the last year. As a scheme within the BCF programme since its inception, much work has been undertaken to develop, implement and embed principles of Ambulatory Care across the system. We have concentrated on defining and embedding our principles, getting up governance around the project and developing services both in the community and the acute hospital. Our system-wide ambulatory care principles include:

- Patients treated as Ambulatory by Default
- Shared decision making for individually tailored patient care
- Locally driven support for patients, centralised when needed
- Extended hours 7 days a week

The core principles of acute ambulatory care delivery will ensure high quality care that builds on existing work on the ambulatory care pathways including the Daily Diagnostic Unit (DDU), Surgical Assessment Unit (SAU) and more recently the Adams Ambulatory Unit (AAU), while expanding the scope of conditions managed out of hospital with flexible follow up, tailored to risk and patient/carer preference. This will support existing clinical teams in the management of the acute care work stream, support the rapid access gerontology clinic and contribute to optimising the usage of acute medical beds. Therefore the core principles include:

- Rapid assessment by competent senior decision makers supported by multidisciplinary teams
- Point of care diagnostics for:
    - rapid identification of pathophysiological disturbance and initiation of definitive medical therapy where appropriate
    - rapid review of patients returning for assessments
    - supporting shorter care delivery times from presentation to returning home
- Access to plain X Ray, ultrasound and cross-sectional imaging as needed
- Parenteral therapies, delivered if required over several daily attendances to a re-engineered level 4 unit
- Therapist and social care interventions as required
- Access to specialist opinion/coordination of additional investigations and follow up

- 7/7 service provision when clinical capacity has increased
    - currently available for 5/7 within existing staffing
    - Interface Physician duty periods 10:00 – 18:30
- Timely communication of information to GPs about changes to ongoing community management in primary care.

We have also done a lot of work trying to understand how patient activity is coded, counted and charged. This work is on-going in addition to further expansion of ambulatory units. We have continued to keep these services in the BCF as we believe the principles of ambulatory care are absolutely essential to patient flow, NEA reductions and DToC reductions. Further, it supports the development of new pathways and the communication around this with practices.

The chart below visualises patient flow through the urgent care pathway including ambulatory care and demonstrates our ambition.

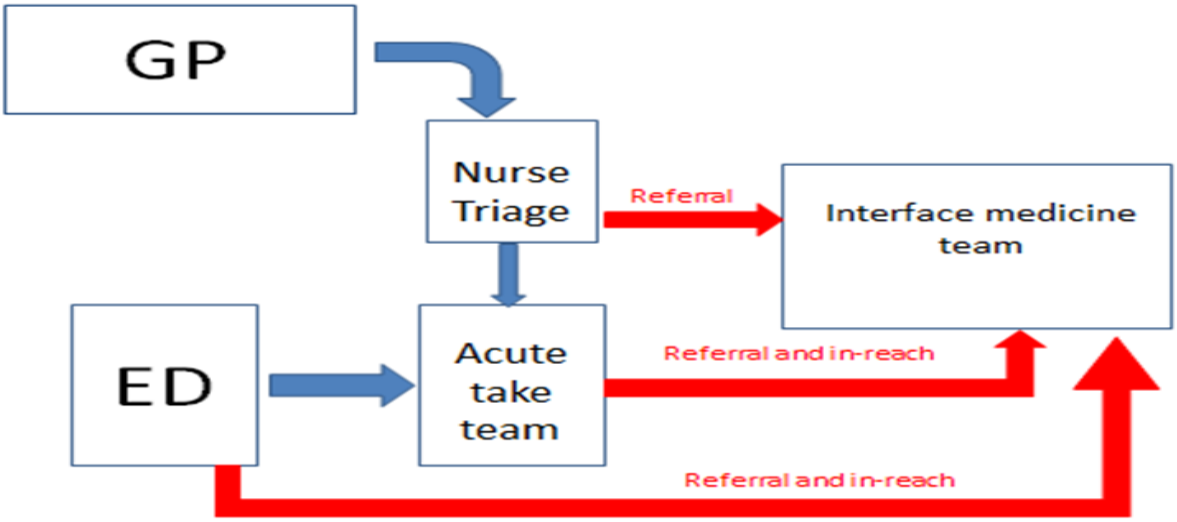

Figure 1: AEC Pathway

2. **Long Term Conditions (Respiratory and Diabetes):** As part of our BCF plans for 2016-17, BCF Board has agreed that we would like to concentrate on the management of LTCs within the community. This includes our proposals to deal with the very high rates of COPD readmissions and Diabetes management in the community.

   Three years ago, a previous attempt was made at having a respiratory task force in Oxfordshire. Respiratory medicine has changed a great

deal in these three years and the ideas from the previous attempt are still as relevant today as they were then.

On 1 April 2013, primary care trusts (PCTs) were formed into clinical commissioning groups (CCGs), which have the means and resources to assist the change of how services are delivered. An objective of the inaugural meeting of the respiratory task force was to create a wish list of how respiratory care could be improved in Oxfordshire. The task force prioritises its work to ensure that improvements are achieved, and to target higher risk factors such as smoking cessation and respiratory A&E attendances for greater benefits. Their work concentrates on the following three areas:

- COPD Readmissions and how to stop patients from going back into the hospital unnecessarily;
- Regeneration of the Respiratory Task Force to support the redevelopment of the pathways;
- Teaching /Training of patients and GPs to increase awareness for better self-management.

3. **Falls Pathways:** Oxfordshire has recently approved a new falls pathway with a view to support more patients from prevention to treatment. The new pathway provides a streamlined service that has greater reach in the community to those that are regular fallers and those that may be at risk of falling based on national and local evidence.

   We anticipate this service to save around 193 NEAs; however detailed modelling is underway to determine what the overall target will be. The service will be operational from October and include both the Oxford Health Foundation Trust and the Age UK.

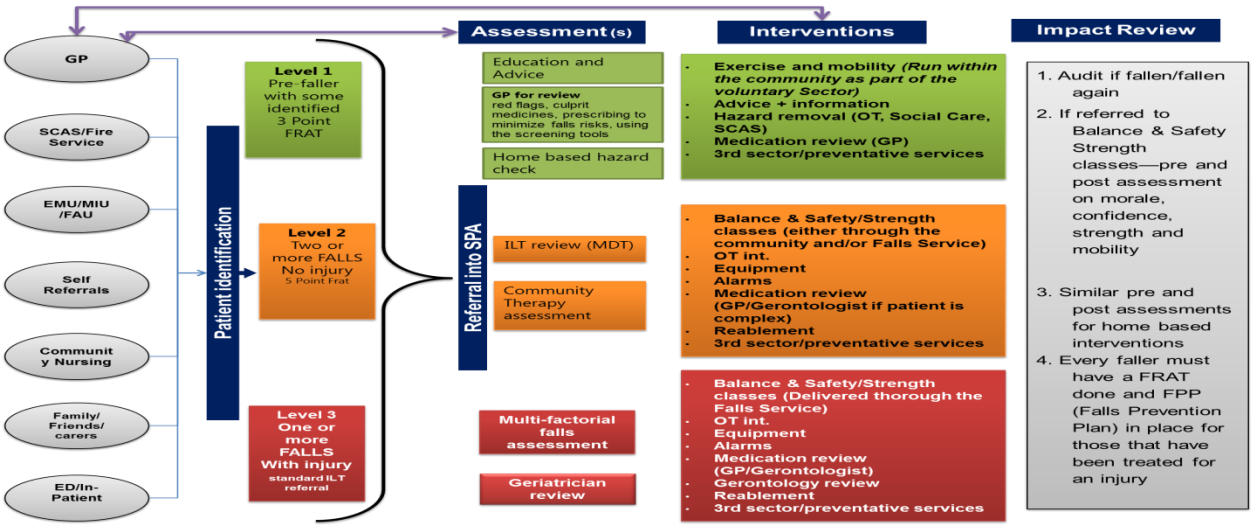

Figure 2: New Falls Pathway

The Falls Pathway has been developed as we know that they are a major cause of disability and the leading cause of mortality injury in people aged over 75 in England. Also, whilst most falls do not result in serious injury, the consequences for an individual of not being able to get up after a fall can include: psychological problems, loss of mobility, depression, increases in dependency and disability, hypothermia, pressure-related injury and/or infection.

We are therefore bringing together commissioners including Social Care, Providers including the voluntary sector and the Fire Service to develop a pathway that;

- Puts Primary Care at the heart of services as the accountable professional;
- Improves prevention;
- Reduces Duplication;
- Improves referral rates and routes; and
- Increases capacity in the community through better trained staff and the use of the Voluntary Sector / Fire Service.

4. **End of Life:** This is an extension of the current EOL projects with better focus and better evidence based interventions. The project aims to set up a palliative care hub and improved access to domiciliary care to support patients that are at the end of life and reduce NELs for this group by about 30% which equates to around 525 NEAs reduced.

5. **Reablement:** The reablement pathway has been redesigned based on a model of the demand requirement to deliver a high performing system (compared to national ASCOF indicators). This will enable us to move

from a fragmented and poorly performing pathway (multiple providers, multiple entry points, unclear criteria, lack of rigor in assessment and move on) to a clear single pathway, focuses on delivering system wide outcomes. When fully mobilised the new pathway will deliver a 10-15% capacity increase, with enhanced response times, greater community pick up and avoidance activity, and improved ambulatory performance.

The new reablement pathway and capacity model have been designed as part of a whole social care post hospital and community support model that includes and enhanced urgent and crisis domiciliary care response (URTS), improved telecare availability, and a new focuses domiciliary care framework (help to live at home).

Investments in an improved social care pathway, including reablement, means that patients will receive appropriate preventative support in the community and will be supported out of hospital in a way that ensures meaningful outcomes. 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 independently. This combination of improved patient outcomes, decreased pressure on acute services, and reduced social care cost characterises the overall approach in Oxfordshire.

2.5 Risks/challenges to the success of BCF in 16/17 and any measures in place/planned to mitigate them

We will approach the implementation of the plan as a whole-system, monitoring progress and mitigating risks through the BCF Board, SRG, Joint Management Group, with ultimate responsibility lying with HWB. 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 reducing non-elective admissions. 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. 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 that is agreed across the stakeholders.

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 are 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.

Finally, whilst the CCG financial position has stabilised, our system partners have seen considerable pressure on their own financial performance and standing. As a health and social care system, taken in aggregate, we may be at breakeven or a marginal surplus (<0.1%) at best.

We have outlined a number of risk that still pose a threat to the delivery of our plan, including mitigating action in the attached Risk Register.

3.0 National Conditions

Oxfordshire system is committed to delivering change through the continuation of BCF in 2016-17. We believe the focus provided by BCF 2015-16 has had a positive impact on the driving service improvements; better relationships across the system and an appetite to better integrate care for our patients.

We have patient involvement in the BCF Plans through various communication and engagement strategies, mainly for the individual schemes that are developed as part of the BCF. Included in this the OCCG's Communication and Engagement Strategy which outline's our commitment and approach to involving the public, patients, carers, partners and other stakeholders in our work. Engaging partners, stakeholders and the public is central to the development of our transformation plans.

There are Patient Advisory Groups for all our current redesign projects, detail can be found in the strategy that has been submitted. In addition there are six voluntary, non-statutory, Public Locality Forums which have been set up to bring the patient voice into commissioning decisions. They were successfully used in the recent consultation on changes to services that were to be provided in the newly built Townlands Hospital in Henley.

3.1 Plans to be jointly agreed

Oxfordshire's plans for 2016-17 are agreed jointly, through the BCF Programme Board and will ultimately have Health and Wellbeing sign-off. The HWB meets three

times per year and assumes ultimate responsibility for the BCF development and delivery of the overarching vision for improving the care and health of local people, aligned to the Oxfordshire Health and Well-being Strategy (2012 – 2016). The HWB has delegated responsibility for delivery of the plan to:

- The BCF Programme Board for co-ordination and assurance against the delivery of the Plan reporting to:
    - The SRG for delivery of the programme.
    - It is proposed that Oxfordshire has a Single Joint Management Group with senior representatives from Oxfordshire County Council and Oxfordshire Clinical Commissioning Group to manage four pooled budgets for adults for effective delivery of health and social care in Oxfordshire. This would replace the four existing Joint Management Groups that currently meet to look at individual pooled budgets for older people, people with learning disabilities, people with mental health conditions and people with physical disabilities.

      A single joint management group for adults will provide an opportunity to
        - have commissioning discussions across all client groups, rather than separately;
        - have an oversight of the issues specific to each client group and common challenges for all;
        - have an overall consideration of issues across the pools or flexibility to match funding to areas of pressure and need irrespective of client group;
        - Streamlined decision making.

      The Single Joint Management Group will meet quarterly, and will be supported by a Pooled Budget Officers Group that will meet on a monthly basis. Commissioners, finance leads and others will meet outside these meetings as appropriate or required. Decision making in relation to the pooled budgets will rest with the Single Joint Management Group unless delegated appropriately.

The BCF Plan 2016-17 HWB sign off is done under delegated authority, which was agreed at the Board Meeting in March, with the following decision:
'*Health & Wellbeing Board agreed with the recommendations in the report which was to delegate the signing off of the BCF to the appropriate officers and to agree that the final version would be submitted to the next meeting of the HWB in July 2016 for endorsement.*

3.2 Maintain Provision of Social Care

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.

OCC is of the view that Adult Social Care is under significant pressure and the County Council under even greater pressure because local government has seen a reduction in funding whilst at the same time an increase in demand. However, the County Council has fully funded the impact on demographic pressures on adult social care. Through the Better Care Fund, there will be a continuation of the same levels of investment as in 2015/16:

- £10.502mm per annum was already being transferred in line with the 2012 Department of Health guidance to NHS England on the funding transfer from the NHS to social care in 2013-14. This continues to be allocated against a broad range of existing schemes, contracts and areas of work. These include equipment and telecare (such as the alert service), intermediate care beds, and crisis response.
- £8m contribution to protecting adult social care services, which provides significant protection for adult social care, not least in avoiding other services having to be cut whilst also meeting increasing demand for care and support.
- £1.350m to meet new burdens arising from the implementation of the Care Act. This has broadly been spent on projects to support transformational work in adult social care designed to help manage increasing demand, both generally and as a direct result of the Care Act including preparing for this implementation of funding reform (although delayed, there is still a need to plan ahead).
- To date, this has included funding for operational teams to support the delivery of Responsible Localities (reshaping the adult social care workforce), development of a new IT system for adult social care including improving recording of Safeguarding, changes to support for carers (from GP-allocated breaks to assessment and support plans), delivery of new duties relating to advocacy, and the e-marketplace / online self-assessment.
- For 2016/17 there remains significant work needed to develop online self-assessment and e-marketplace, and the development of new posts including a Business Support Manager post to support DTOC and a specific Learning Disabilities Care & treatment review post. It is also anticipated that there will be a greater emphasis on support for carers, but we await further guidance and details of the exact breakdown in the Local Authority Social Services Letter, which will be sent by the Department of Health to the Directors of Adult Social Services in due course.

The identified schemes within the Better Care Fund plan 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.

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 a continued emphasis on ensuring the right care in the right place, first time, and the vital links between intermediate community care and hospitals

Investments in an improved reablement 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 independently. This combination of improved patient outcomes, decreased pressure on acute services, and reduced social care cost characterises the overall approach in Oxfordshire.

Disabled Facilities Grants

In Oxfordshire there is a strong history of joint-working between the County and District Councils to effectively utilise Disabled Facilities Grants (DFG's) to support people to live independent and successful lives.

The nationally allocated capital sums for DFG's are passported to District Councils and deployed through Home Improvement Agencies to make adaptations to property, informed by close working relationships with adult social care (occupational therapists in particular) to determine need and how to meet this as effectively as possible.

3.3 Agreement for the delivery of 7-day services across health and social care to prevent unnecessary non-elective admissions to acute settings and to facilitate transfer to alternative care settings when clinically appropriate

The Oxfordshire system is committed to improving the availability of health and social care services 7 days per week, particularly where they support discharge and prevent unnecessary admissions at weekends. It is also important to note that OUH is National Early Implementer for 7 day working. The system completed a scoping exercise to determine the extent of 7 day services currently in operation, together with existing plans to increase the availability of services at weekends that increase discharge/admission avoidance, by organisation. Many of the actions from the scoping exercise have been completed and we know that:

- All organisations across the Oxfordshire system have plans in place to extend routine working across a 7 day week to meet the 20/20 challenge.
- The majority of services delivered by OHFT operate 7 days per week, from 08.00 to 22.00 as a minimum. Recent changes to the working patterns of

community therapists, who now work 7 days a week, have also increased the availability of community services at weekends.

- Adult social care has recently improved operations at weekends so that there is now a social work presence across acute and non-acute inpatient bedded areas; within the EMUs; and in A&E departments.
- OUH ensures that ward rounds take place twice every day, including weekends and bank holidays. The availability of diagnostics and pharmacy services has been recently increased at weekends and there are plans to extend this further. All critical diagnostics are already provided 24/7.
- A number of care agencies and residential care providers have started working flexibly to support the system at the weekend and particularly during high demand holiday periods.
- The evidence suggests that discharges are increasing at weekends. We are working with NHSE as part of the Winter Review Group to develop standardised Shared Operating Procedures for Discharge.
- Oxford University Foundation Trust have an action plan to meet the standards which are agreed with NHSIQ as part of Phase 1 of the early implementer programme for 7 Day Services. The work is currently focussing on 4 of the core standards 2, 5, 6, and 8. There is currently a major data collection process commencing on the 28th March will update our performance against the standards once published in May.
- Improvements against access to primary care over 7 days NHS England has commissioned extended hours in addition to the standard out of hour's provision. The CCG has also commissioned Neighbourhood Hubs at weekends and evenings. We are currently reviewing this provision to ensure we deliver against the standard and meet local need.
- Oxford Health (OH) deliver Emergency Department Psychiatric Service which provides MH assessment and support to staff 24/7 in OUH – JR response time 1 hour and HGH 1.5 hours – all age.
- OUH provide Inpatient Psychological Medicine Services across all wards 7 days a week, providing MH assessment and support to staff – all age
- OH provides crisis cover within mental health teams 24/7 – all age – response time 4 hours.
- Also there is a MH practitioner attached to the Thames Valley Police teams for Street MH triage between 1800 and 0445, to advise and support TVP with MH assessments and reduce the number of inappropriate s136's
- OCCG are testing using a OH MH practitioner being embedded in the SCAS control room, between 1800 and 0445 to provide MH advice and support call handlers and paramedics with 111 and 999 calls to prevent inappropriate conveyance to ED.

Adult social care is moving towards a new structure “Responsible Localities” which will establish a Rapid Response service with the remit to deliver a same day (Monday to Friday) response as required. Combined with improved crisis response services, this will help to reduce the amount of emergency demand at weekends by ensuring people have better planned access to the care they need. Responsible Localities will bring the Adult social care teams into a coterminous arrangement with the CCG and community health providers. Alongside this, we are working on an Estates strategy which will ensure that teams working across similar geographical areas are able to provide joined up services to the local population. Integrated working between partner agencies will ensure 7 day accessibility to the right response which will prevent unnecessary non-elective admissions to acute settings.

It is recognised that the necessary adult social care infrastructure to prevent unnecessary admissions must include the provision of a responsive domiciliary home care and Crisis service. Oxfordshire County Council is reviewing the commissioned service offer to ensure that services available in a crisis are understood, accessible and responsive. With regards to crisis services, the new Urgent Response and Telecare Service will encompass the Alert Service, the Carers Support, and the Crisis Service. This new service will work closely with the new Reablement Service and the new home care services.

- Service users can be referred from
  - Telecare
  - Single point of Access (SPA)
  - Social and Health care Team
  - Emergency Duty Team
  - ASC Locality teams
  - Carers Support Plan

Those entering via telecare will be visited within 45 minutes of their call. Others will be visited at an appropriate time depending on the urgency of the referral. This will be between 4 and 48 hours of referral.

After the first visit this service will provide a further 48 hours of care during which time a referral will be made to Reablement or Home care. Should neither of these services be able to accept the referral, this service will provide Contingency Home Support until one of the above is able to take the referral

3.4 Better data sharing between health and social care, based on the NHS number

The Oxfordshire system continues to work towards better data sharing across health and social care and relishes the advantage of having joined-up technological solutions across agencies, to ensure the safe, secure, timely and contemporaneous sharing of

data in the best interests of people who need to access health and social care and support.

The CCG IM&T Strategy, submitted as supporting evidence, has driven the successful delivery of shared electronic health records, patient consent for information sharing, electronic appointments and repeat prescriptions.

The current strategy will be replaced by a system wide strategy developed by the STP IM&T Work stream as part of the Transformation Programme. Working with the Academic Health Sciences Network (AHSN) we have plans to develop an eHealth Informatics Platform for Oxfordshire that will enable digital health and care transformation.

An interoperability platform has benefits for patients, the health and care system and research by:

- Empowering patients to self-care and improve experience and outcomes
- Facilitating system transformation through improved efficiency, new care models and payment mechanisms
- Providing general insights into patient care and enable digital innovation across the value chain
- Improved access to rich data sources for transformational research

All of the Transformation Board clinical work streams under review are likely to require technical solutions and data interoperability for the success of their plans which could be facilitated by such things as:

- Email/skype consultations to facilitate appointments delivered at places other than hospital outpatient settings or a patients 'own' GP practice
- Access to a single digital health record and patient data in real time to facilitate multidisciplinary assessments and treatment or treatment in a patient's own home
- Telehealth that enables patient participation and full engagement in their own health journey

We intend to take every opportunity to make use of technological solutions as a means of delivering responsive, cost effective and patient friendly services. Further detail will be provided in the STP Transformation Plan. Oxfordshire's Digital Roadmap is being developed in partnership with local providers through the Transformation Board IM&T work group. The Commissioning Support Unit is undertaking a stocktake and a strategy will be developed by the IM&T work group.

The Oxfordshire Care Summary (OCS) is the locally agreed application programming interface (API) system which will accept data from any system, provided the data, the

system and the processes for sharing the data meet clinical safety and information governance standards. The NHS number is the primary identifier for health and social care services within the OCS, and this has been adopted by adult social care and all the health providers across Oxfordshire. The system-wide use of the NHS number is steadily increasing as the rollout of the OCS becomes increasingly widespread.

The OCS commenced implementation in March 2013, and access is currently available to authorised clinicians in OHFT, OUH, SCAS and GP practices. The access is via an N3 connection to a website, controlled by user ID and password protected, or by a single-sign-on context sharing access from within a user's electronic patient record. The consent model is one of 'implied' [1] patient consent to share, and explicit permission to view at the point of care, where possible.

Role-based access (that is to say, restrictions on the data which can be viewed according to the role of the user) is also under development as main access is currently for NHS clinicians only.
Provider organisations and GPs have signed up to information sharing protocols to enable the information to be shared, under the Oxfordshire Information Sharing Framework. All statutory organisations including OCCG, OCC, OHFT, OUH, Principal Medical Ltd (PML: GP deputising service) and the South Central & West Commissioning Support Unit have signed up to the framework, as of March 2015. GPs have signed up practice by practice over the past two years and progress over 2015 has resulted in all Oxfordshire GP practices are now signed up to this agreement. There has been incentivised through the Local Investment Scheme (LIS) for primary care to enable. The framework is an overarching agreement which sets the standards by which information can be shared and was developed by a multi-agency information governance steering group.

Adult social care implemented a new IT system (Liquidlogic LAS) in November 2015. LAS uses the NHS number as an identifier and currently the council has over 90% of service users with an NHS number in the system. The council, provider and partners are currently investigating ways in which the council and community health provider Oxford Health can join the Oxfordshire Care Summary later in 2016 via the MIG. The Oxfordshire Care Summary is a 'single view' platform which enables partner agencies to view specific information held on service users.

3.5 Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional

We continue to stratify and support the top 2% of the population most at risk of an emergency admission, supporting the role of the GP co-ordinator through the implementation of advanced care plans for all in the high risk group, with case management to avoid unplanned admission. We know that a majority of NEAs come

from patients within this risk group and therefore acknowledge the importance of targeted work to reduce unnecessary acute activity.
Our top 2% has been identified through a risk stratification exercises involving:

- Age: those over 65 years where Oxfordshire is experiencing above national average population growth.
- The top 2% of patients (9,700) identified as most at risk of an emergency admission using the ARG risk stratification tool.

Over 26% of those most at risk of emergency care in Oxfordshire live in residential care and nursing homes. It is for this reason that the Oxfordshire BCF plan continues to include an initiative to provide greater health prevention support to the independent residential home sector, through 'proactive medical support to care and nursing homes'. From evaluation, we know that this scheme is making an impact in reducing NEAs (please see the BCF Dashboard).

To address these issues, support implementation of a greater level of ambulatory care and our Care Closer to Home plans we are piloting the delivery of integrated care through 17 co-located Community Integrated Locality Teams across 6 localities. The integrated teams bring together health and social care colleagues in neighbourhood teams working alongside 4-6 GP practices. The outcome for individuals is 'one plan and one approach' to meeting their needs, a better experience and more efficient use of resource.

Adult social care is moving towards a new model which will bring health and social care into a coterminous relationship. This is a positive step forward within Oxfordshire and will allow teams of health and social care professionals, working to GP patches of 30,000 to 50,000 to working as multi-disciplinary teams, assessing and jointly planning for local people whose needs would benefit from such an approach.

The changes from Responsible Localities are expected to be implemented during the autumn 2016 with a plan to push forward on closer integrated working and planning once the initial foundations are in place.

Adult social care is scoping the upgrade of its' IT system LAS with a view to the deployment of online portals; enabling better sharing of information between individuals and professionals involved in the delivery of health and social care across the County.

Dementia
Partners across Oxfordshire have been working together to ensure that people with dementia and their carers receive the appropriate level of support wherever they live within the County, and regardless of whether they receive their diagnosis in primary, community or secondary care. We believe that the single dedicated county wide

Dementia Support Service will improve the current level of support by increasing provision and scope. Our OCCG operational Plan references our activity trajectory for dementia diagnosis for 2016/17 shows that we aim to achieve and maintain delivery of the dementia diagnosis target from quarter 2.

The benefits of the single Dementia Support Service are as follows:

- The service provision will be standardised and equally available to all people with dementia and their carers across the county
- Increased capacity that will be achieved by;
  - Redesign of current provision to avoid duplication and maximise effectiveness
  - Increased number of dementia advisors
- Current resources will be more efficiently utilised and staff will be up skilled to achieve better outcomes
- Resources will be allocated following demand analysis ensuring support is offered to people with dementia and their carers according to their need
- On-going support ensuring crises are prevented by proactive management and early identification
- Responsive service according to needs
- Creating a joined up approach between health, social care and voluntary sector.

We also aim to improve the dementia services by:

- Continuing to build capacity for GP diagnosis and management of dementia, building on work undertaken in 2015/16
- Raising GP awareness of post-diagnostic support services, establishing strong links between primary and secondary care and developing a model of specialist nurse support in the community.
- Ensuring that each person with dementia and every GP practice has their own Dementia Advisor creating strong links between GP practices and community support.
- Working with secondary care to improve waiting times from GP referral to diagnosis ensuring referrals for memory assessment are seen within 30 working days.
- Ensuring, where possible, that a diagnosis is given at the first appointment but where a second appointment at a memory clinic is needed ensuring that diagnosis is provided within 70 days of initial referral.
- Monitoring delivery of dementia training by providers
- Working in partnership with OCC to source specialist residential and nursing homes for people with dementia.
- Supporting the Oxfordshire Dementia Action Alliance (ODAA) to encourage communities and local businesses to become more dementia friendly.

3.6 Agreement on the consequential impact of the changes on the providers that are predicted to be substantially affected by the plans

BCF Plans have been developed in partnership with our providers through the BCF Programme Board. We work on an on-going basis with all of our stakeholders to identify where and how our plans may impact providers financially and in regards to activity.

The current DToC plan is also working to better understand if any proposed or implemented changes will have an impact somewhere else in the system. This is worked through as part of the system equilibrium work and addresses challenges as they arise or are foreseen.

We have also been working to align our operational plans with the provider plans to ensure that parts of our system are not adversely impacted by schemes that are included within this plan.

Finally, the BCF Programme aims to operate a risk arrangement to achieve NEA and DToC target, which aims to reduce the risk for providers/commissioners alike and supports the ambition that money follows the patient.

3.7 Agreement to invest in NHS commissioned out of hospital services

Oxfordshire has a wide range of out of hospital services to deliver better integrated and personalised services supporting patients in the community. These range from preventative service provision (to be developed for diabetes and COPD) to community services for End of Life Services and a new Falls Pathway.

This approach is strengthened by the Transformation Board, which is leading on developing a Care Closer to Home Strategy which sets out our vision to enable more people in Oxfordshire to access care at or closer to home. Our ambition is to achieve a step change in developing community services and to reduce demand for hospital care by:

- Developing local systems of care that bring together general practice, community health and social care, the voluntary sector supported by specialist advice to proactively and comprehensively manage the local population's health.
- Integrating care around patients not organisations, promoting health and wellbeing, offering rapid access for urgent problems and a comprehensive prevention approach for patients and populations at risk of poor health

- Engaging partners and front line staff and clinicians in the development of our Care Closer to Home transformation plans.

This development to enable out of hospital-based care requires greater senior medical presence and outreach into community services, most particularly the EMUs, our DToC incentives and interface with primary care and the integrated neighbourhood teams. It is likely to involve acute sector specialist clinicians adopting new ways of working, including delivering remote interface support and advice via telemedicine, to clinicians delivering services within patient's own homes.

We have therefore agreed to that the 2016-17 BCF Programme will aims to reduce non-elective admissions by 1000 episodes based on projected OCCG activity growth for the same year. As mentioned above, we expect that increased Ambulatory Care and End of Life projects to feed into this to a large extend. The cost savings associated with this are put into the contingency and we are in discussion with stakeholder's relation to the risk share arrangements.

3.8 Agreement on a local target for Delayed Transfers of Care (DTOC) and develop a joint local action plan

The Oxfordshire DTOC Plan for 2016-17 builds on the learning from the 2015-16 initiative *Re-balancing the System* and is designed to reduce both the number of people who are delayed in the Oxfordshire system and the length of time patients stay in hospital when medically fit for discharge.

The plan is part of a broader initiative to design and deliver equilibrium into the Oxfordshire system, creating the right capacity and processes at each stage of the patient's journey. As this larger piece of work is still in development, this DTOC plan focusses specifically on the reduction of delays through until March 2017.

3.8.1 Learning from *Re-balancing the System*

This initiative:

- Released a number of in-patient beds and redeployed the resource into an extended Emergency Assessment Unit
- Purchased intermediate care beds at scale in the community to step down people who were medically fit for discharge but who could yet move to their final destination
- Created a multi-agency hub to manage flow into and out of the intermediate care beds and co-ordinate medical, social worker and therapy cover

As the initiative progressed the hub developed into a full command and control structure and has extended from hospital based teams to include procurement and contracts staff in the local authority. The hub has interrogated processes around assessment and transfer and has been given responsibility for allocating all resource across reablement, domiciliary care, residential and nursing home with the specific

requirement that it allocates resources both to meet patient need and to address pinch points across the system.

This approach has had significant impact:

- 30% reduction in delays in context of average 6% quarter by quarter increase – forecast q4 2015/6 on trend of 181
- Reduced DTOC length = 13% increase in proportion DTOC of less than 1 week
- Delayed days per 100,000 population (BCF Indicator) in January at 890.2 from November figure of 1004.5
- Fewer DTOC days (2,041) in December and January than in same period 14/15
- Reduction in secondary delays within the pathway: people waiting to move on from reablement to domiciliary care packages has reduced from c 30 each day in Dec 15 to 16-20 each day in March 16. This frees up capacity for people awaiting discharge from hospital

Generally there is better flow in the system and a better understanding of barriers to flow when they occur. Resources can be and are being allocated to manage these flow issues as they arise and the daily command and control structure has escalation processes that ensure senior clinical and managerial oversight.

3.8.2 The Oxfordshire DTOC plan for 2016-17

The 3.5% target of bed days lost to DTOC equates at current length of stay to a weekly snapshot of 73 patients delayed, which would represent a 50% reduction in our current system figure. As a system Oxfordshire has reviewed where and how we can reduce our weekly delay across the different forms of delay. Our approach builds on the strengths of the *Re-balancing the System* initiative
The plan focusses on the following areas:

- Focus on assessment and choice processes that will reduce unnecessarily delays
- Continued grip on daily and weekly operations to ensure that flow is managed and available resources deployed appropriately
- Planning for discharge from the point of admission

OCCG's operational plan has prioritised the DTOC Plan and investment in resources will be made available that will support the move to a system that can work in equilibrium.

3.8.3 Operational control

The command and control function that was so effective in the *Re-balancing the System* initiative will be maintained.

- Gold Command and Control daily calls
- The daily teleconference uses shared information on system wide available resource and patients to prioritise to limited resource – e.g. Home care hours, community hospital beds
- Command and control assures consistency and timeliness of assessment and choice processes
- System wide workforce strategy with agreed priorities across the partner agencies
- Escalation of underlying issues to the Chief Operating Officers weekly DTOC Control Group
- Oversight and assurance from the SRG Chief Executive Officers group monthly

3.8.4 DTOC delivery plan

The Oxfordshire system has maintained a level of delay of patients that could be reduced by a more co-ordinated approach to some key processes.

Assessment	• Increased use of discharge to assess models – home (80 Discharge to assess intermediate care beds) and CHC (12 interim funded discharge to assess beds) from May 16 • Assuring integration of assessment functions through the Gold Command and control centre from April 16 • Additional social worker and therapy input into discharge to assess beds to support timeliness of assessment from May 16
Awaiting further non-acute NHS care	• Improving pull through from integrated reablement service (below) [date TBC] • Achieving an optimal length of stay in community hospital of no more than 21 days via 2 weekly MDTS • Additional beds for intermediate care and interim waiting (31 and 18 in phase 1) whilst moving to optimum length of stay in all other intermediate care and community hospital beds and building home carer workforce • Review of all waiting in OUHFT for Community hospital with view to home discharge with rehabilitation model or more intensive rehabilitation on site
Awaiting residential home placement or availability	• Increase the availability of residential and nursing placements through an alignment of commissioning intentions and market availability • Use interim beds for people needing residential/nursing homes where there is no need for them to remain in hospital environments • Tighter choice policy with 7 days to select home – agreed timeline for allocation of
Awaiting nursing home placement or	

availability	care home price. • Dynamic purchasing model for residential and nursing home care from September 16
Awaiting care package in own home	• Purchase an extra 14000 hours of care by 31/3/17, and increase the home care workforce • Integrated reablement and discharge service with more effective pick-up, outcomes and discharge and/or move on to next step in pathway
Choice	• Review the Oxfordshire choice protocol to a 7 day process from June 16 • Assuring integration of choice policy functions through the command and control centre from April 16
Oxfordshire people delayed in other systems	• Development of a Royal Berkshire patient protocol by June 16 • Potential use of beds on the Townlands site from July 16 • Weekly calls with Northamptonshire to plan discharges from April 16

3.8.5 Trajectory and strategic control

Performance against the DTOC plan will be reviewed monthly by the Chief Operating Officers in the DTOC Control Group and escalated to the SRG Chief Executives Group.

The DTOC control group have assessed the system confidence in the elements of the DTOC plan as follows:

	Attributed DTOC at 10/3/16	**Planned DTOC at 31/3/17**	**Trajectory**	**Notes**	**Clear actions to address**
Waiting Community Hospital Beds	**25**	**16**	From Sep	Demand and capacity analysis completed by OUH. Model for accelerated rehabilitation now developed and agreed by providers	Partial
Intermediate Care Beds	**5**	**3**	From May	Additional beds to continue to be purchased	Yes
CHC D2A beds	**0**	(assessment reduction)	From June	Needs to be filtered in through May	Yes
Interim Beds	**4**	**2**	From May	OCC to advise nature and locations	Yes
Nursing Home beds	**15**	**8**	From Sep	OCC introduce dynamic purchasing model by Sep 16; focus on particularly EMI beds	Partial

SHDS / ORS (reablement) Hours	**26**	**17**	From Oct	Awaiting resolution of the integration plan. Procurement solution being sought.	Partial
Domiciliary Care	**8**	**4**	From April	Extra hours managed and deployed through command and control hub	Yes
Assessment	**14**	**8**	From April	(1) CHC interim funding delays addressed by CHC D2A (2) Potential for hub assurance re assessment delays	Yes
Choice	**22**	**11**	From June	New choice policy will need Board ratification in May- need to understand impact of national policy	Yes
Out of county	**8**	**4**	From July	(1) need to consider use of Townlands beds for bed-based D2A (2) need to review processes re RBFT delays	Partial
Total	**127**	**73**			

3.8.6 Implementing the learning from the DTOC summit 22 April 2016

As discussed at the DTOC summit there remain a number of challenges to the plan that will need to be addressed as part of the longer-term equilibrium work:

- Resolution of integrated reablement
- Homecare workforce –part of plan but significant challenge
- How to manage nursing home market at reasonable price
- Out of area protocols
- Rehabilitation whilst waiting for community hospital

Approaches to these were explored with useful advice and insights which are being enacted locally. In addition, the system will develop approaches to care planning at all stages of the patient journey through hospital. We will test this through the use of 7 day stranded patient metric.

3.8.7 DToC Risk Share Arrangements

The Council and the Clinical Commissioning Group are both committed to increasing the hours of home care purchased each week to meet increasing demand, reduce the number of people permanently placed in care homes, and to help avoid hospital admissions and support people to return home as soon as they are fit to do so.
The Council has committed £2.1m of new funding to the Home Support budget within the Older People's pool to purchase additional capacity in the Home Support market. It is calculated that the Council will need to purchase 270 new hours of home care per week over the course of 2016/17. After taking into account the impact of attrition the Council expects to deliver growth of 10% in the number of home support hours commissioned per week from a baseline of 20,400 hours per week.

It is proposed that if the Council does not fully meet this commitment and there is an underspend against the Home Support expenditure budget, the Clinical

Commissioning Group will recoup in full any underspend up to the value of £2.1m. This will help to offset additional costs in the NHS arising from people admitted to and/or delayed in hospital (acute or intermediate care beds) as a result e.g. the additional CCG investment in intermediate care beds.

However, subject to evidence provided by the Council that the inability to source home care was due to capacity in the market rather than sufficient funding, and if there are demonstrable costs to the pool arising from increased admissions to care homes as an alternative to home care, the Clinical Commissioning Group may agree to the reallocation of this funding within the pooled budget.

Progress in sourcing the additional hours of home care will be jointly tracked weekly and monitored on a quarterly basis by the Joint Management Group. This will be measured by the average numbers of new hours commissioned per week in the quarter, cumulative progress towards the 10% increase in total weekly hours per week, and the total spend against the budget.

4.0 National Metric

4.1 Non-elective admissions:

Reduction 2016-17	1,000
Expected activity	**55,724**

We were successful in halting the expected growth for NEAs for 2015-16 and analysis suggests that we are in a good position to repeat this performance again this year. Therefore, we have committed to reducing expected non-elective activity by 1000 episodes.

4.2 Admissions to residential homes and care homes (how you intend to reduce residential admissions)

Forecast 15/16	Planned 16/17
442.8	440.9
526	536
118,780	121,570

Last year (2014/15) Oxfordshire placed 595 or 11.4 people per week in care homes. This was the 34th lowest rate of admissions in the country and in the top quartile nationally. In the first 11 months of this year 546 people (or 11.4) per week have been placed.

The target set - 572 people reflects 10.5 placements per week on average. It is an increase on last year's target but an improvement on actual performance

and reflects the need to review highly expensive care packages as this underpins at least one of our agreed savings. This performance will still put Oxfordshire above the national average

The range of admissions in the last 5 years has varied from 557 to 626. This target, last met in 2011/12, is therefore a challenging target, but still represents a stretch on previous years

The council uses all demographic funding to support care in the home as this is the strategic direction of all partners locally. However the council will be reviewing highly expensive care packages this year, which will put a pressure on meeting this target.

4.3 Effectiveness of reablement (how you intend to increase reablement)

Forecast 15/16	Planned 16/17
83.2%	83.6%
288	418
346	500

A multi-agency project has been set up to improve access to reablement and the performance of the whole reablement pathway. Work streams include developing a commissioning pathway, and improving the interface between the different parts of the reablement pathway.

4.4 Delayed Transfers of Care

		16-17 plans				
		Q4 (Jan 16 - Mar 16)	**Q1 (Apr 16 - Jun 16)**	**Q2 (Jul 16 - Sep 16)**	**Q3 (Oct 16 - Dec 16)**	**Q4 (Jan 17 - Mar 17)**
Delayed Transfers of Care (delayed days) from hospital per 100,000 population (aged 18+).	Quarterly rate	2487.7	2333.5	2146.0	1958.6	1535.9
	Numerator	13263.0	12440.8	11441.5	10442.1	8233.8
	Denominator	533,140	533,140	533,140	533,140	536,106

Our DToC action Plan demonstrates how Oxfordshire will reduce DTOC to 3.5% of total occupied bed days by 31/3/2017 and has translated this to a weekly target of 73 DTOC per week.

This amounts to a 50% reduction on the current average monthly performance. Each of the initiatives within the plan has a trajectory for delivery overseen by a SRO appointed from across the system. The Control Group will monitor progress weekly and mitigate any risks to delivery.

The metrics for the DTOC Action Plan 2016-17 will monitor the impact of the range of initiatives that have been developed from local learning and the ECIP High Impact Changes. These measures are currently being tested with a view to signing them off the planned Oxfordshire DTOC Summit hosted by NHS England on 22 April.