Health and Wellbeing Board
07 July 2022

Oxfordshire Integrated Improvement Programme - Update

Programme Directors:	Helen Shute (Programme Director, Oxfordshire Community Services) Lily O'Connor (Oxfordshire Director for Urgent Care)
System Execs / SROs:	Sam Foster (Chief Nurse, OUHFT) Dr Ben Riley (Exec Managing Director, Oxford Health FT) Karen Fuller (Interim Corporate Director of Adult Social Care, OCC) Matt Powls (Executive Place Director, BOB ICS)

RECOMMENDATION

The Board is RECOMMENDED to

Note the content of this report, the progress made since the December Board meeting to develop a detailed programme of work with identified priority projects.

Board members are asked to consider the opportunities this work presents to improve the health and wellbeing of people across Oxfordshire; how they might communicate this shared vision within their organisations; and to commit their organisation's support and an appropriate amount of staff time and resource to the work.

Contents

Executive Summary 2
Defining the Services and Activities in scope 3
- Our Strategic Priorities 4

The Integrated Improvement Programme in detail 1
- Programme Structure 1
- Summary of programmes, projects and objectives 1
- Delivering the change 1
- Dedicated resources 1
- Programme governance 2
- Engagement 3
- Conclusion 3
- Appendix 1 1

Executive Summary

- The Health and Wellbeing Board has approved a mandate for the Oxfordshire health and care system to develop a strategy to improve the health, wellbeing and independence of Oxfordshire residents and to optimise the use of our community-based workforce, buildings and resources. To inform and shape this work, eleven principles were developed through public engagement last autumn and ratified by the Board at its December 2021 meeting.

- This report outlines the progress made on the programme of work to deliver these objectives and principles. Recognising the overlaps and synergies that existed across multiple community-based projects and services, the system partners have agreed to bring together the Community Services Strategy work and Urgent and Emergency Care work into a single Integrated Improvement Programme for Oxfordshire. This report details the programme’s priorities and scope, governance arrangements and sets out the next steps for delivery.

- The need for transformation in both Community Services and Urgent and Emergency Care is widely accepted and much work is already underway to develop and deliver this, based on local and national priorities. As teams across Oxfordshire have come together over the course of the last 18 months, it has become increasingly clear:

    - That the scale of transformation we need, across the spectrum of health and social care providers, requires a single, dedicated Programme Management Office at place level to act as ‘air traffic control’ and support the successful delivery of a diverse yet interconnected set of transformative programmes
    - That the historical separation of ‘Routine Community Care’, ‘Urgent and Emergency Care’ and ‘Preventive Care’ is artificial and increasingly unhelpful, especially when we consider them through the eyes of the local population, and that we need to consider their development and integration in the round to achieve the best outcomes for our citizens, our workforce and from our resources. This is key to deliver the principles the public strongly support to improve the experience of care, provide more joined-up services, and to deliver more resilient care closer to home.

Following detailed consideration and design, a new, integrated strategy, the Integrated Improvement Programme, has been developed with key strategic priorities, priority programmes and a focused set of projects for the coming 12-18 months. More detailed work is now underway to map existing workstreams and resources into the programme.

Defining the Services and Activities in scope

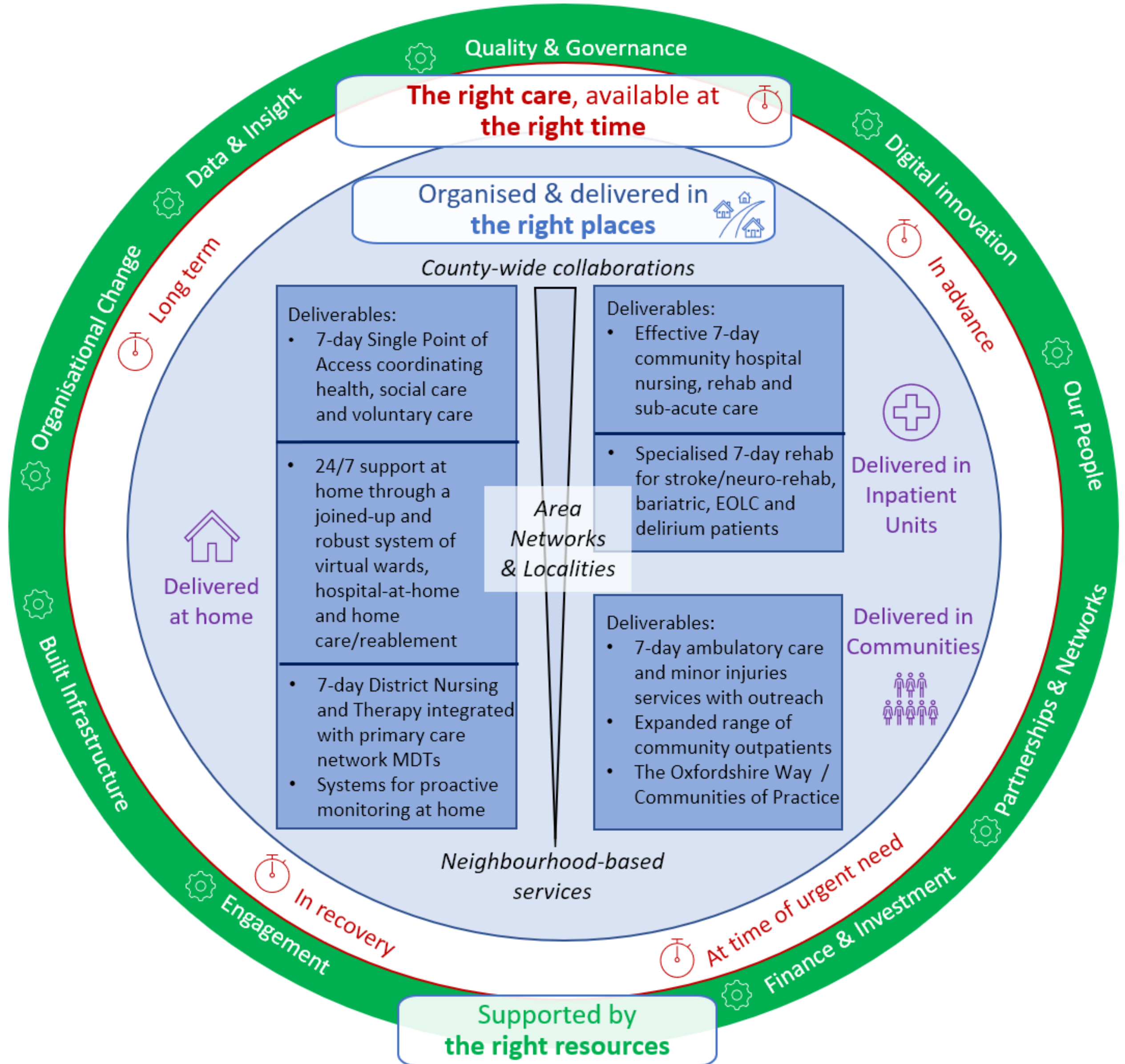
It is important that, as system partners, we have a common understanding of the scope and purpose of the Community Services and Urgent & Emergency Care (UEC) pathways. When we talk about the scope of work of the Integrated Improvement Programme, we are considering a range of health, social care and voluntary sector services across Oxfordshire, which include:

- Services that deliver preventative and proactive care and support in home and community settings, which aim collectively to maintain health and wellbeing, optimise the management of long-term health conditions and prolong independent living
- Urgent care delivered in homes and community settings that reduces the need for ED attendance and ambulance conveyance, including (not exhaustively) urgent 'first contact' assessment and triage 24 hours a day for people experiencing a health or care crisis; this includes urgent assessment and responses (health and social care), ambulatory care, minor illness and injuries, virtual wards and hospital at home services
- The services we traditionally associate with the care of older people in the community, such as district nursing and therapy, care home support, community hospital care and care during the last phase of life
- The integrated leadership, management, coordination and enabling resources and infrastructure for all these services, in order to deliver a more effective, personalised and joined-up experience of care for residents and families.
- Although many of these services cater predominantly for older people, including those with frailty or multiple health conditions, primary care and many community-based urgent care services take a population-based approach and provide care for people of all ages, including children and young people.

Our Strategic Priorities

Although our ambition for Oxfordshire is broad, it can be distilled into four high level, essential strategic themes:

The right care, at the right time, in the right places, supported by the right resources



A. The Right Care at the Right Time – 'keeping people safe at home'

- We need to work in a more integrated way to deliver care interventions which are more efficient and effective. This means thinking more clearly in service design about the benefits of the interventions our services provide and what current evidence and technology enables us to do and not do - as well as the enablers (processes, structures) they require
- We need to develop our skill mix and working practices to ensure that our workforce has the skills and experience required to deliver evidence-based care interventions at the point of need, reducing delays or the need for ED attendance or onward referral
- We need to focus on delivering interventions that lead to measurable improvements in outcomes not process-based numbers
- We need to provide more proactive and preventative care 'upstream', shifting focus and resources into this area to delay and reduce health crises for patients and improve system sustainability
- We need to find ways to reduce time spent in bed-based rehabilitation pathways to improve independence.

What this programme will involve:

- This programme focuses on the design, modelling and implementation of more integrated, joined up and cost-effective professional and clinical care pathways delivering improved health outcomes relevant to UEC and community care. It considers this aspect of service transformation through the lens of *when* patients need support:
    1. **In Advance**
        - Preventive and planned care pathway (including the Oxfordshire Way, health improvement and wellbeing, social prescribing, long-term condition care, proactive care for complex patients, and voluntary sector support)
    2. **At Times of Need**
        - **First contact and navigation** - including initial assessment, triage and signposting through 111, single point of access, OOH GP services, Urgent Care Centres, minor injuries units, triggering a coordinated response
        - **Intensive community support** – provision of a coordinated and effective response in the community, including **acute Virtual Wards**, integrated hospital at home services, ambulatory care units, urgent community response, End-of-Life care (e.g. RIPEL)
    3. **During Recovery**
        - Community rehabilitation and recovery pathway (including community inpatient and bed-based care, home reablement and 7-day-a-week rehabilitation). Patients who require support to return home either with reablement or long-term care are discharged on Pathway 1. Pathway 2 is for those requiring 'stepdown' bed-based rehabilitation.

- We are bringing <u>all three of the above workstreams</u> under a single programme due to their interdependency; better preventative care will reduce health crises and the corresponding demand. Better deployment will support this shift to proactive and preventative care.

- A reduction of lengths of hospital stay across pathway 1 (reablement at home) or pathway 2 (bed-based rehabilitation) will result in greater capacity to reduce the number of people ready to leave bed-based care who are either in acute or rehabilitation beds.
- This programme of work starts with a population-based approach to prevention and self-care, to target support for people with long term physical and mental health conditions and finally supporting people with complex care requirements and/or at higher risk of deterioration. While services for older people will naturally be favoured through this approach, the services and the proposals will apply across adult services
- The local Multidisciplinary team can access the available population-based data to identify the people who would benefit from an initial intensive assessment followed by interventions to promote wellbeing and improved independence.
- The new integrated pathway includes same day emergency care, short term and anticipatory care planning for the local population, including those in care homes. It is based on the development of teams across primary care, community nursing, specialist nursing, social care, therapists, pharmacists, RIPEL (EOL), and access to acute specialists, all working as an MDT to support Primary Care Network populations.
- A central **transfer of care team** will also be developed where patient transfers are coordinated to increase the number of people returning home who require either no ongoing care or a discharge to assess pathway home. A focused approach to discharge to assess at home will start with the general medical and trauma wards at the JR and HGH sites. This will continue to be developed across all beds bases in Oxfordshire.
- The combined digital and physical Single Point of Access (SPA) is a key enabler.

B. The Right Places – enabling people to be assessed and treated in their own home

- We need to shift care closer to home – it's better for the patient and more deliverable for the system – with knock-on benefits for, for example, staff, morale and efficiency. This means both care in people's homes and where we offer services across the county
- In the urgent and emergency care (UEC) pathway, staff currently work in a fragmented way across the three Oxon Hospital @ Home teams and an Urgent Community Response team with medical oversight and daily MDT from the acute physicians, plus complex referral systems with social care and primary care colleagues
- This programme focuses on re-imagining *where* services should be delivered, turning the concept of North, City and South Area Networks into reality and considering the projects and support PCNs need to take on the role envisioned in the NHS Long Term Plan
- In addition, the creation of a truly integrated Single Point of Access (SPA) team will be scoped and developed to support the Right Care, Right Time programme across the county
- To reduce the need for hospital-based UEC, assessments using diagnostics and treatment that would normally take place in secondary care are carried out in the patient's own home

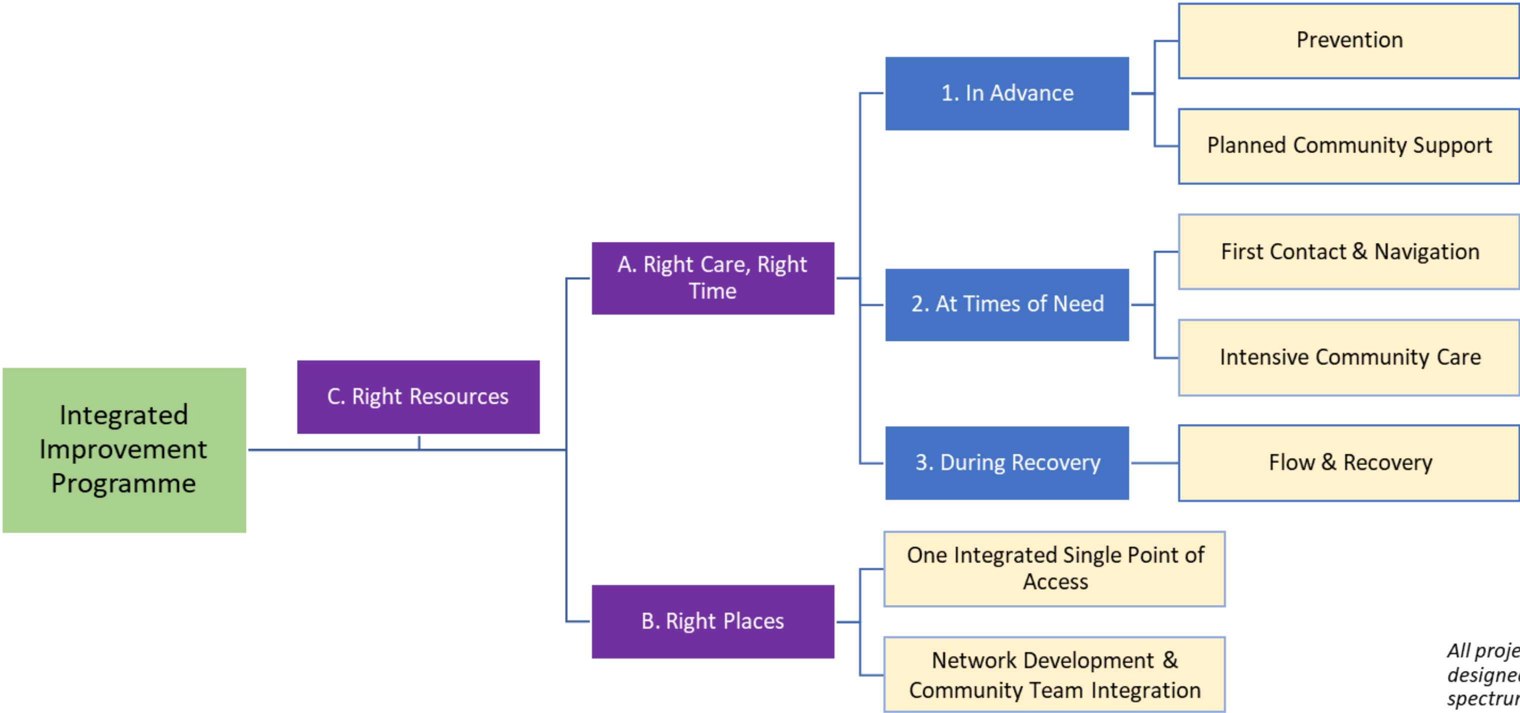
- An integrated team bringing together hospital at home and the acute virtual ward will support and treat the person in their own home until they are ready to be transferred to their primary care team and Neighbourhood-based preventive care
- Oxfordshire has acute digital virtual wards being set up but requires an SOP for admitting / discharging patients with responsibility to ensure it is maintained and kept up to date. It will hold a central list of all those on the virtual ward
- Examples of the care that can be delivered in the person's own home range from point of care testing, 24-hour infusions to lung/cardiac ultrasound. If a person requires further diagnostics, they can have these carried out either on the day or the following day in a Same Day Emergency Care unit (SDEC)
- To develop this at pace it requires further integration of all the teams working in a collaborative way and for 999 crews and the control room to be able to refer directly to the virtual ward pathway(s)

C. The Right Resources – making Oxfordshire 'ICS-ready'

- This is an overarching facilitation programme focused on enablers under the principle of 'do once', whether that is providing information to support decision making or aggregating needs from each of the workstreams to consider (and deliver) them in the round
- We need to support this work holistically to provide teams with the right input and support to design and deliver integrated, transformation in community services, whether that's a need for data, engagement, workforce, technology, estates or myriad other interdependent activities necessary to meet our goals
- Part of this programme is the need for a full, funded *organisational change* programme. We cannot achieve transformation without it. This needs to be properly funded and everyone needs to understand this goes far beyond the legal requirements into a hearts and minds transformation.

The Integrated Improvement Programme in detail

Programme Structure



All projects and teams will be designed to incorporate the full spectrum of health, social, community and voluntary sector inputs and outputs

Summary of programmes, projects and objectives

Strategic Aim	Programme	Programme Objective	Project	Project Objective
The Right Care at the Right Time	A. Prevention	A targeted population health programme to enable people and families to stay healthy and live as well as possible in their own homes. We will achieve this by strengthening preventative services and activities to ensure we are providing earlier support to people, carers and families closer to where they live, through stronger community networks	A1. Extending the LiveWell online resources	To develop, promote and maintain a centralised, easily accessible online resource to support self-help and signposting to relevant community services across Oxfordshire.
			A2. Activating our communities to improve health (including the Oxfordshire Way)	To promote wellbeing and independence for the people of Oxfordshire by improving co-production, establishing local communities of practice and healthy, active communities. Will enable identification, assessment and delivery of support and other interventions for higher risk people and families
			A3. Integrated population health and vaccination service	To integrate multiple existing community child/adult vaccination and health promotion services into a single, integrated vaccination and population health service that will deliver at-scale programmes for population immunisation, reduction of health inequalities and improving the health of cohorts with outlying clinical outcomes
	B. Planned Community Care & Support	A programme to support patients, carers and families to live more independently at home for longer. We will do this by delivering planned care and support to individuals in a more integrated and personalised way, mobilising the full range of formal and community networks to prevent health crises and reduce demand on formal healthcare services	B1. Extending Enhanced Healthcare in Care Homes	To build on existing care home support to deliver a comprehensive care and support package for care home residents, including 24/7 urgent and emergency care, intensive community care, preventive, planned and End of Life care.
			B2. Delivering sustainable 7-day planned community care	To design and implement the new process and costed plans for commissioning and delivery of sustainable planned community care, including the wraparound enablers for effective 7-day working and resilient staffing
	C. First Contact & Navigation	To deliver more streamlined access to health advice, assessment and services when they are needed, 24 / 7	C1. A 24/7 integrated first contact and navigation pathway for Oxfordshire	To deliver a 24-hour, 7-day first contact care and navigation pathway for the Oxfordshire population (all ages) that is able to provide effective triage, assessment and initial treatment/support and consistently. This will safely navigate people with further needs to the right care, at the right time, in the right places.

	D. Intensive Community Care	To manage acute deterioration by providing a period of stepped-up care and monitoring at home and / or in the community, providing treatments that would traditionally take place in hospital where it is in the patient's best interest to do so.	D1. Implementing a 24/7 integrated intensive community care and support pathway for Oxfordshire (including Acute Virtual and Virtual Care Wards)	To deliver an integrated system of inter-connected services that provide the care that enables a person experiencing an urgent health or care need to remain at home (with a more intensive level of support for a period of time), when they are at risk of being admitted to a hospital bed unnecessarily.
			D2. Implementing an integrated, multi-provider End of Life Care pathway that dovetails with First contact, ICC and planned care pathways	To deliver an integrated approach to the planning, provision and management of EOLC in Oxfordshire
	E. Flow & Recovery		E1. Developing a new Discharge to Assess (D2A) pathway, bed base and MDT	To redevelop the Hub beds into a D2A service with a larger MDT inputting into them to keep LOS at a minimum, leading to reduced time in secondary care and supporting the person to be assessed in a more appropriate setting, dovetailing with the CH rehab pathways
			E2. Optimising Community Hospital In-patient rehabilitation and nursing care	To develop costed plans and options for Community Hospital inpatient pathways that address changing population needs, best practice, workforce and financial sustainability challenges
			E3. Developing a system-wide Transfer of Care Hub	To create a single integrated Transfer of Care Hub Team across the partner organisations / different inpatient settings to streamline flow, discharges and provide a joined-up view on the best use of available beds and resources
			E4. Implementing a Reablement Task Force	To reduce the duration of the reablement journey (in both P1 and P2), by creating a task force to increase capacity in the pathways and focus on reducing time in and dependency on reablement services.
	F. One Integrated Single Point of Access (iSPA)	To develop a unified, integrated Single Point of Access for Oxfordshire, providing residents and	F1. Development of a phased and costed programme plan for	To work with partners to identify the access priorities for each organisation and residents - and the opportunities to consolidate

The Right Care in the Right Places		professions with 7-day access to and coordination of the full range of health, social and voluntary sector services, whenever they need them, and serving as a virtual and physical hub for an integrated, multi-disciplinary workforce	the development of a unified, integrated Single Point of Access for Oxfordshire	resources and deliver services more effectively through a new SPA, to develop a PID/delivery plan.
	G. Network Development and Community Team Integration	To establish the networks, structures and resources required for partner organisations, residents and other stakeholders to engage, plan and work together successfully at appropriate levels of scale and deliver their objectives to improve the health and wellbeing of the population	G1. Area Network Development (North / Central / South)	To develop Network Areas as an organised grouping of local health and care services, voluntary and community groups, Primary Care Networks, Community Hubs, secondary care and Local Authority teams, who work closely together to improve the health and wellbeing of their population.
			G2. Developing the integrated Neighbourhood Team	To develop the local multi-professional and multi-agency community team with responsibility for planning and delivering the care of older, frail or LTC patients within a defined population or geography (e.g. the residents of one or more PCNs).
The Right Resources	H. Cultural and Organisational Change	To deliver a comprehensive organisational change programme across organisations and teams to facilitate and embed place level transformation	H1. System Level Change Management	To provide joined-up, practical support tailored to teams across all levels of organisations to break down barriers and transition to new, shared ways of working
			H2. Extended Programme Teams	To change ways of working to integrate wider support teams into the programme to deliver specialist practical support and prioritisation and ensure the enablers to delivery are proactively planned for and in place

This is a summary of a working document and may be updated in response to local and national priorities.

Delivering the change

Much of the work that sits under our priority projects is already underway and delivery of our key national priorities (such as the Urgent and Emergency Care priorities) have not been lost. Rather, we are taking this opportunity to work across system partners to map existing projects and to consider what we need to:

- Start – what are our gaps – or where do we need to think differently / more strategically now we are focused on our key priorities
- Stop – what doesn't fit within our programme, needs to be done differently, or duplicates other work / services
- Continue – what is already underway, in the right way, that delivers our programme and national priorities?

As part of this process, we are mapping the resources already dedicated to these projects so we can consider how best to use / redeploy what we already have and where our gaps in expertise, capacity or experience lie. This is a complex piece of work across all partners and work is already underway to complete the exercise. Once we have finalised this work we intend to 'lift and shift' the work that forms part of the programme under the leadership of the PMO. Engagement around this will be key and it is important we give these teams the right experience as we ask them to work differently. This is a key focus of our work to get the governance (see below) and processes right before we make the change.

In future, many of the projects that have been reported separately will be reported through the lens of the Integrated Improvement Programme. We will have a single reporting structure, including highlight reports, that ensure teams can focus more of their efforts on delivery of the projects, spending less time duplicating work for different Boards.

This structure and process is a key marker of our approach in future. The work we capture in this programme determines our scope, our priorities and our work plan. This does not prevent improvement work taking place within individual organisations, rather it ensures a clear and deliverable plan for integrated improvements across partners. Over time, new priorities (national and local) will emerge. To be included in this programme, the Board will review both fit with our strategic priorities and whether they can be integrated into existing projects and programmes. This will ensure we minimise duplication and maximise resources.

Dedicated resources

In addition to existing project resources that are being mapped and redeployed as part of the exercise outlined above, the Oxfordshire Integrated Improvement Board (OIIB) have approved the appointment of a small, core team of specialists to resource the System Programme Management Office (PMO). Recruitment processes are now underway. These are not roles that have existed before and they are crucial to the success of this new structure and approach.

The remaining resource gap we need to fill is from our support teams. The new approach requires us to fully integrate the specialist teams who support our services (not exhaustively, finance, HR, estates, quality, data, IT). The scale of transformation

we need to deliver means new ways of working not just for our clinical teams but those who will need to adapt to everything from pooled budgets, to shared HR contracting, cross-organisation estates, aligned QC systems and robust 24/7 IT support). We need to identify system representatives (with ringfenced time) for each of these functions who play the following key roles:

- System representative and decision maker on key groups and Boards. (This will require a mandate from, and robust communication and feedback loops with, their peers)
- Deployment of specialist support into project teams
- Aggregation of project and programme asks for validation, prioritisation and approval

The Oxford Health / Oxford University Hospitals Provider Collaborative has identified helping unblock some of these conversations and sticking points to be a key role they can play in helping drive the outcomes we need.

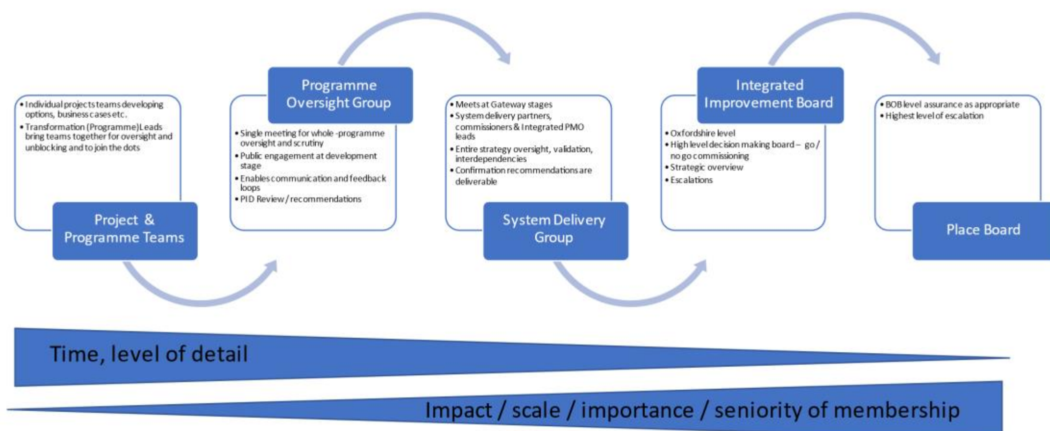
Programme governance

Across Oxfordshire we are agreed we need to better empower teams and enable them to take decisions more quickly. As a team of system partners we have identified a number of ways to do this:

1) Act in concert:
    a. ‘Team Oxfordshire’. Agreement across system partners that we commit to this shared process and act as one
    b. Joint communications to our organisations and teams to ensure there’s no room for dilution or confusion
2) A new approvals and flow process

Approvals and flow

Enabling rapid decision -making and scrutiny appropriate to scale / importance of decision. Each level has focused membership, ToR and Scheme of Delegation. Timings are synchronised to minimise delays while ensuring join-up.



(A larger scale copy is available at Appendix 1)

For each group, between the project and programme teams to OIIB, we are defining:

- **Why:** Clear purpose and accountabilities
- **When:** Meetings will be synchronised to ensure enough time for each stage to consider proposals and make amendments before paper deadlines for escalation. We will work back from established Place Board dates
- **What:** Clearly defined delegation that is consistent and everyone understands – spanning both that in PIDs (Project Initiation Documents) and parameters for improvement projects for existing services. Not every decision needs to go to every stage.
- **Who:** Membership that is appropriate to the stage in the process and the expertise / input we need. This includes fuller engagement with PCNs and earlier stage involvement for citizens and representatives of groups such as Healthwatch

Engagement

We are mindful of the need to begin more detailed public engagement. We believe the foundational work we are doing now to finalise the detail, put in place the scaffolding roles for the PMO (Programme Management Office) and set up the governance to create a single line of sight will stand us in good stead to create the narrative and specifics we need to gain meaningful input into our work. This single programme and narrative will enable a much more cohesive and powerful conversation with our citizens than the fragmentation we previously saw.

Conclusion

Much has been achieved over the last few months and while there is still much to do we have a clear plan to achieve it. The pace of progress will depend on how quickly we can fill the core PMO roles. Once it is in place, monthly reporting will be streamlined and we will be able to present regular, clear and comprehensive reports on progress.

Appendix 1

Approvals and flow

Enabling rapid decision -making and scrutiny appropriate to scale / importance of decision. Each level has focused membership, ToR and Scheme of Delegation. Timings are synchronised to minimise delays while ensuring join-up.