HM Government

NHS England

BCF narrative plan template

This is a template for local areas to use to submit narrative plans for the Better Care Fund (BCF). All local areas are expected to submit narrative BCF plans. Although the template is optional, we ask that BCF planning leads ensure that narrative plans cover all headings and topics from this narrative template.

These plans should complement the agreed spending plans and ambitions for BCF national metrics in your area's BCF Planning Template (excel).

There are no word limits for narrative plans, but you should expect your local narrative plans to be no longer than 25 pages in length.

Although each Health and Wellbeing Board (HWB) will need to agree a separate excel planning template, a narrative plan covering more than one HWB can be submitted, where this reflects local arrangements for integrated working. Each HWB covered by the plan will need to agree the narrative as well as their excel planning template.

Cover

Health and Wellbeing Board(s).

Oxfordshire

Bodies involved strategically and operationally in preparing the plan (including NHS Trusts, social care provider representatives, VCS organisations, housing organisations, district councils).

a. Bucks, Oxfordshire and Berkshire West ICB, including GP reps from Primary Care Networks [ICB]
b. Oxford University Hospitals NHSFT [OUH]
c. Oxford Health NHSFT [OH]
d. South Central Ambulance Service [SCAS]
e. Oxfordshire County Council (integrated commissioning, operations and Public Health) [the Council]
f. West Oxfordshire DC [WODC]
g. Oxford City Council [the City]
h. South Oxfordshire DC/Vale of White Horse DC [S&VDC]
i. Cherwell DC [CDC]
j. Oxfordshire Association of Care Providers [OACP]
k. Oxfordshire Care Homes Association [OCHA]
l. Age UK Oxfordshire [AUK]
m. Order of St John Care Trust [OSJ]
n. Oxfordshire Promoting Independence and Prevention Group (PIP)

How have you gone about involving these stakeholders?

Briefings to Oxfordshire Urgent Care Delivery Group [UCDG], Urgent and Emergency Care Board [UEC], Mental Health & Learning Disability/Autism Delivery Board and Promoting Independence and Prevention Groups. The metrics and demand and capacity projections were reviewed in UCDG and UEC and recommended to the Joint Commissioning Executive (JCE) of the Council and ICB for adoption. The deployment of the Additional Discharge Funding was reviewed by the Place Based Partnership (PBP) Committee and approved for deployment by the JCE. UCDG, UEC, PIP and PBP are multiagency groups with membership including District Councils, PBP and Healthwatch.

Governance

Please briefly outline the governance for the BCF plan and its implementation in your area.

1. The Oxfordshire Health and Well-Being Board has overall responsibility for the Better Care Fund Plan and will review and approve the plan at its meeting on 29 June 2023. The HWB has delegated responsibility to the Council Corporate Director for Adult Services who briefed the Chair of HWB and the Cabinet Lead for Adult Social Care prior to submission of this plan. The Place Director for the ICB obtained approval for the Plan from the ICB Executive on 26 June 2023 Oxfordshire has developed a new s75 NHS Act 2006 agreement between the Council and BOB ICB that incorporates the Better Care Fund. This new agreement came into force on 1 April 2023.

2. The development of this Plan and proposed trajectories for the BCF metrics; the allocation of funding against the schemes in the Plan, including for the Additional Discharge Funding; and the demand and capacity plan has been overseen by the system Urgent Care Delivery Group and approved by the system wide Urgent & Emergency Care Board. The demand and capacity, BCF metrics and proposed deployment of the Additional Discharge Funding was reviewed by the system wide Place Based Partnership.
3. Commissioning oversight of the Plan and pooled budgets in the s75 NHS Act 2006 is delegated by the Council and the ICB to the Joint Commissioning Executive. The Deputy Director, Joint Commissioning is the Pooled Budget Manager for the s75 agreement (including the Better Care Fund) and accountable to the Joint Commissioning Executive. Within the s75 agreement, the commissioning of Better Care Fund Plan services is delegated by the ICB to the Council via the Health, Education and Social Care integrated commissioning team. This team is led by the Deputy Director and hosted by the Council.
4. Proposals in respect of the Disabled Facilities Grant and Home Improvement Agency are developed by the County Housing Forum, a joint meeting of District Council leads and the Lead Occupational Therapist Oxfordshire County Council and the integrated housing OTs and lead commissioners.

Executive summary

This should include:

- Priorities for 2023-25
- Key changes since previous BCF plan.

Oxfordshire's key priorities for the BCF in 2023-25 are

1. The expansion and embedding of the Oxfordshire Way. This brings together BCF funding and planning with Public Health and ICB funding into a programme to address health inequalities in Oxfordshire through a focus on loneliness, exercise and connectivity. The programme builds community capacity and strengths-based assessment and support to enable people to access what works for them.

2. The development of a more integrated approach to supporting people to live as independently as possible in their own home across housing (including extra care housing), adaptations, assistive technology and equipment.

3. Supporting the implementation of the system Integrated Care Plan to improve the assessment and care planning for at risk populations and the implementation of responses linked to Urgent Community Response, Same Day Emergency Care and Enhanced Healthcare in Care Homes. This approach includes mental health and learning disability and/or autism pathways integrated into neighbourhood teams. As part of this model we will build on and develop our existing falls response.

4. Home First Discharge to Assess for people who are admitted to hospital. We have created a Transfer of Care hub that now manages all discharges from Oxfordshire acute and community bed bases and will seek to expand to neighbouring trusts. We will increase the number of people going home; we will assess people at home; and when people need to go into bed-based reablement we will increase the throughput to get them home.

5. Further develop our demand and capacity planning capability including around community capacity and in mental health and learning disability and autism discharge pathways.

6. A continued focus on inequalities throughout all of these priorities.

The key changes in the 2023-25 BCF Plan are

The expanded focus on prevention and community capacity to underpin all of our plans to keep people well, living independently and in their own communities

The development of a new Carers Strategy

The development of a Home First approach both in terms of expanding community services and enabling people to return home after a hospital stay

The focus on people living with mental health, learning disability and/or autism

A focus on health inequalities across all of our other plans

National Condition 1: Overall BCF plan and approach to integration

Please outline your approach to embedding integrated, person centred health, social care and housing services including:

- Joint priorities for 2023-25
- Approaches to joint/collaborative commissioning
- How BCF funded services are supporting your approach to continued integration of health and social care. Briefly describe any changes to the services you are commissioning through the BCF from 2023-25 and how they will support further improvement of outcomes for people with care and support needs.

Oxfordshire's key priorities for the BCF in 2023-25 are

1. The expansion and embedding of the Oxfordshire Way. This brings together BCF funding and planning with Public Health and ICB funding into a programme to address health inequalities in Oxfordshire through a focus on loneliness, exercise and connectivity. We aim to create the conditions where people can live independently in their own home within resilient communities. This approach underpins all other aspects of this plan around admission avoidance, falls prevention, home first on discharge and reducing long-term care in residential settings. The programme builds community capacity, area coordination and strengths-based assessment and support to enable people to access what works for them.

2. Developing a more integrated approach to supporting people to live as independently as possible in their own home across housing (including extra care housing), adaptations, assistive technology and equipment.

3. Supporting the implementation of the system Integrated Care Plan to improve the assessment and care planning for at risk populations and the implementation of responses linked to Urgent Community Response, Same Day Emergency Care and Enhanced Healthcare in Care Homes. This approach includes mental health and learning disability and/or autism pathways integrated into neighbourhood teams. It will also include a review that builds on our current falls response and associated services.

4. Home First Discharge to Assess for people who are admitted to hospital. We have created a Transfer of Care hub that now manages all discharges from Oxfordshire acute and community bed bases and will seek to expand to neighbouring trusts. We will increase the number of people going home; we will assess people at home; and when people need to go into bed-based reablement we will increase the throughput to get them home. We will review the capacity of our bed based rehabilitation services in 2023-24 to explore options to redeploy resources into Home First wherever possible in 2024-25

5. Further develop our demand and capacity planning capability including around community capacity and in mental health and learning disability and autism discharge pathways.

6. A continued focus on inequalities and the needs of unpaid carers throughout all of these priorities.

The planning and deployment of the Better Care Fund is led by the Health, Education and Social Care Integrated Commissioning Team. This is joint funded by the Council and the ICB

and hosted in the local authority. Our s75 NHS Act 2006 pooled commissioning budget is much larger than the BCF at £400m. We will continue to review during 2023-25 the opportunities to increase the scope of the Pooled Budget especially in relation to prevention and children's services.

In 2023-25 the BCF expenditure plan has been expanded to include a greater emphasis on prevention and to deliver via the Additional Discharge Funding our ambitions for Home First Discharge to Assess from acute bed bases, and a range of initiatives to support the timely and effective discharge for people living with mental health, learning disability and/or autism and in particular those who are homeless.

The BCF investment and this plan is designed to support system-wide initiatives:

- the development of a Health Inequalities programme bringing together Public Health and ICB Inequalities funding with the BCF to create community capacity and localised support to enable people to stay well and independent in their own communities and
- the system wide Integrated Care Plan to expand community services and avoid hospital conveyance and admission led by the Place Director for Urgent Care. This programme is funded partly by BCF and partly from other ICB funding streams.

The BCF plan for 2023-25 has been built on learning from the winter-funding round in 2022-23 and on the development of demand and capacity approaches. There are areas both of uncertainty (especially in relation to community intermediate care capacity) and development (implementation of a range of new initiatives) that mean that this plan will need to reviewed and reprofiled during 2023-24. At the point of submission, the plan does not fully deploy the Additional Discharge Funding as we anticipate that some of the new initiatives may need implementation or other funding and may also lead to changes in demand across pathways that may need to funded. The plan will be reviewed in Q2 2023-24 to confirm this further ADF investment and to confirm any changes to the plan for 2024-25.

National Condition 2

Use this section to describe how your area will meet BCF objective 1: **Enabling people to stay well, safe and independent at home for longer.**

Please describe the approach in your area to integrating care to support people to remain independent at home, including how collaborative commissioning will support this and how primary, intermediate, community and social care services are being delivered to help people to remain at home. This could include:

- steps to personalise care and deliver asset-based approaches
- implementing joined-up approaches to population health management, and proactive care, and how the schemes commissioned through the BCF will support these approaches
- multidisciplinary teams at place or neighbourhood level, taking into account the vision set out in the Fuller Stocktake
- how work to support unpaid carers and deliver housing adaptations will support this objective.

Oxfordshire has a 6 part approach to enabling people to stay well, safe and independent at home for longer

1. We are developing community capacity that underpins all of our asset-based approaches. The BCF investment plan includes a grants programme to support neighbouhood and community groups to meet the needs of their communities with a focus on combatting isolation and supporting exercise. Within the BCF Plan we commission Age UK to provider information and advice (Live Well Oxfordshire) and support through the Community Links service to enable people to identify what is important to them and access resources to enable them to retain their independence. This BCF funded service works alongside Public Health and ICB funded programmes that work in the 10 most deprived Wards in Oxfordshire, provide exercise support (Move Together) delivered by the voluntary sector, seek to develop Healthy Place Shaping and map into NHS Social Prescribing and District Council community support.

During 2023-24 we are mapping this range of services and inputs under the Oxfordshire Health Inequalities programme. We will identify opportunities to consolidate the approach and increase impact. Particularly we are working with voluntary and community sector partners to develop approaches to measuring impact and mapping those successes back to the BCF metrics in relation to avoidable admissions, admissions to long-term care and discharge to usual place of residence. It is likely that this capacity and capability will in turn support the delivery of the future BCF recovery measure.

2. Adult Social Care has developed the model of strengths-based assessment and asset-based planning known as the Oxfordshire Way. This approach now underpins the Home First Discharge to Assess models funded from the BCF. The Oxfordshire Way builds upon the development of Community Capacity above.

3. The BCF funds a range of services that support a more integrated approach to keeping people well in the community. The BCF funds extra care housing, the integrated community

equipment service jointly commissioned and managed across the Council and NHS; use of telecare and assistive technology. These services are under review during 2023-24 as part of the development of a new Assistive Technology strategy for Oxfordshire.

4. The BCF also funds a range of services that are being developed into new Integrated Neighbourhood teams in 2023-24 as part of the Oxfordshire Integrated Care Plan. This will bring together PCNs, social care, community health and the Voluntary sector working with the community capacity as set out above.

5. In 2022-23 Oxfordshire undertook a review of our support for carers co-produced with carers and organisations that work with them. In Q2 we will conclude an engagement on the future model for supporting carers across health and care settings and a common outcomes framework so that unpaid carers know what to expect and we can measure impact across different providers. The BCF funds Carers Oxfordshire and personal budgets for carers. This has been expanded for 2023-24 to increase the capacity of the service. We will carry out a review of the different forms of respite available to carers in Q2 2023-24. We have also expanded our BCF funded offer through Dementia Oxfordshire to support more carers earlier in the diagnosis journey of the cared-for in response to findings in our survey.

6. Oxfordshire will develop a more integrated approach to supporting independence through housing adaptations in 2023-24 in a major review of the opportunities to co-ordinate, integrate and increase impact. There is already strong operational co-working around housing adaptations: the DFG pays for Housing Occupational Therapy teams around the County that work closely with housing teams and all of our Home Improvement Agency services are now either delivered directly by District Councils in a partnership or a directly commissioned service. There are also a range of district housing-BCF interfaces eg the role of Community Safety approaches in supporting integrated strengths-based assessment and care planning, and local district-led initiatives around community support as part of tenancy sustainment or around falls risk. There is an opportunity for the BCF to deepen and extend the joint working across these and other related areas (e.g. extra care housing allocation, development of move on accommodation for people in step down pathways). This work will be led by the Council and will include two aspects: the opportunities to develop assistive technology, community equipment and adaptations into a range of options to support people to stay at home led by the Council's Principal OT together with housing leads and commissioners; and a review of the wider interface of the BCF with housing to identify opportunities to increase options to deliver more integrated approaches.

National Condition 2 (cont)

Set out the rationale for your estimates of demand and capacity for intermediate care to support people in the community. This should include:

- learning from 2022-23 such as
    - where number of referrals did and did not meet expectations
    - unmet demand, i.e. where a person was offered support in a less appropriate service or pathway (estimates could be used where this data is not collected)
    - patterns of referrals and impact of work to reduce demand on bedded services – e.g. admissions avoidance and improved care in community settings, plus evidence of underutilisation or over-prescription of existing intermediate care services);
- approach to estimating demand, assumptions made and gaps in provision identified
    - where, if anywhere, have you estimated there will be gaps between the capacity and the expected demand?

  how have estimates of capacity and demand (including gaps in capacity) been taken on board) and reflected in the wider BCF plans.

Oxfordshire was adversely affected by a major data outage in 2022-23 which impacted on our Community Health provider and that situation is not yet fully resolved. This has significantly impacted on our ability to map demand and capacity in this area and forms part of the plan for 2023-24: we will undertake a full review of demand and capacity in Q2 to inform the plans including investment for 2024-25.

We have assumed a 5% increase in demand where we can assess that in the light of the data outage.

In terms of demand for community social support and for reablement we understand the demand and have commissioned responses to meet that. We have commissioned the

Community Links service from Age UK and although the forecast demand exceeds the contracted service we are confident that the range of other services funded by the BCF and elsewhere as part of our community capacity building will meet these needs. In terms of community reablement, the projected demand from our new Home First Discharge to Assess service will mean that overall services will need to expand. All referrals for reablement come into the Home First team. The provider contracts are designed to flex according to demand and we have strong capacity in our market in terms both of reablement and domiciliary care after significant recruitment to our Live Well at Home Framework in 2022-23 (currently over 90 accredited providers).

We do not use reablement in a bedded setting in Oxfordshire and there is no evidence that it is needed in our Home First model. In terms of short-term social care, most of this will be routed through to Home First in the first instance which provides both reablement and domiciliary care and is not counted separately for demand or capacity purposes. As noted above we have strong capacity to support people at home and if a bed is needed short-term we have planned respite capacity within our main residential and nursing home block contracts. This demand is not currently measured separately but performance will be reviewed in Q2.

The Urgent Community Response service is funded to meet the planned demand for 2023-24. Our challenge is two fold and this will form part of the review in Q2:

> The UCR is being developed as a single front door for all community intermediate health care. Therefore any therapy assessment for rehab and the initial response is within the UCR figures. However, the impact of this deployment on planned care in the community is still being evaluated, and the extent of any gap in capacity to meet intermediate care demands is not yet fully understood
>
> As noted above this is compromised further by the data outage. We anticipate being able to address this gap during Q2

As with reablement, we do not routinely use bed-based rehabilitation as step up from the community. The commissioned step up beds are generally used for assessment and short-term care for frailty to avoid conveyance to acute settings. Again, we cannot currently assess the flow from these step up beds into bed-based rehabilitation and this will be reviewed during Q2

National Condition 2 (cont)

Describe how BCF funded activity will support delivery of this objective, with particular reference to changes or new schemes for 2023-25, and how these services will impact on the following metrics:

- unplanned admissions to hospital for chronic ambulatory care sensitive conditions
- emergency hospital admissions following a fall for people over the age of 65
- the number of people aged 65 and over whose long-term support needs were met by admission to residential and nursing care homes, per 100,000 population.

Oxfordshire has been rolling out a programme of initiatives as part of the system Integrated Care Plan in 2022-23 and this will continue in 2023-24. The range of services include

Support for on the day demand from primary care: Urgent Care Centres will triage 95% of all NHS 111 referrals

Single point of access via UCR for all clinicians

Development of integrated neighbourhood teams with support from Urgent Community Response and health professionals MDT

These plans have had some success in the reduction of non elective admissions in Q3 and Q4 of 2022-23. There are now established virtual wards in the City and Bicester and the plan is to roll these out during 2023-24 beginning with Banbury. Analysis of the demand data and from audit in Emergency Departments has emphasised that a key factor in the decision to attend is often linked to proximity rather than the presenting condition and risks. Therefore a key focus is on the City and Banbury.

The BCF funds Hospital at Home and Emergency Multi-disciplinary Assessment units which are being developed into the integrated neighbourhood model together with Urgent Community Response and the Primary Care Network based teams including for Enhanced Healthcare in Care Homes.

We anticipate that the continued development of these approaches will lead to an ongoing improvement in our trajectory to reduce non-elective admissions in 2023-24. The evidence is

that the key factor is in the management of frailty where there are multiple long-term conditions.

		2022-23 Q1 Actual	2022-23 Q2 Actual	2022-23 Q3 Actual	2022-23 Q4 Plan
Indirectly standardised rate (ISR) of admissions per 100,000 population (See Guidance)	Indicator value	169.1	146.6	190.5	185.0
	Number of Admissions	1,315	1,140	1,481	-
	Population	691,667	691,667	691,667	691,667
		2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan
	Indicator value	172	140	176	176

Oxfordshire has been an outlier for falls-related admssions for a number of years with several hotspots within the County. In 2022-23 the performance improved. We believe that in significant part this was due to work in the Integrated Care Plan above. There was a call before convey pilot between UCR and ambulance services and a review of fallers in Emergency Department where there was no case for admission. There has been a reduction of 10% in attendees after a suspected fall and the assumption is that by identifying fallers at risk of further falls but prior to an injury requiring admission we are able to divert people into community services that avoided that later episode.

The BCF already funds both a preventative strength and balance class approach delivered by Age UK which is being extended into a further "upstream" service via Public Health funding in 2023-25. The BCF also funds the community Falls Service which works with people identified at serious risk of falling in a planned care model. There are several other initiatives both to mitigate the risk of falls and to assess and divert people into community and other services that could help improve strength and balance, as well as the clinical pathway interventions. Oxfordshire is applying for funds via the ICB for a digital pilot to manage falls risk in Care Homes; Raiser chairs are deployed in extra care and some care home settings and available to support UCR in peripheral stores; there are faller initiatives being run in the wider community by the City Council and by the Fire Service home risk assessment service. And there is the review of assistive tech, equipment and home adaptation as set out above. Oxfordshire has the opportunity to make a big impact on falls building on and aligning current and planned initiatives and we will develop this plan in 2023-24 for roll out from Q3 and throughout the lifetime of this plan. The review of the BCF plan in Q3 will determine if this areas needs further investment in 2425. We are confident we will maintain the reduction in falls achieved in 2223

		2021-22 Actual	2022-23 estimated	2023-24 Plan
Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.	Indicator value	2,102.6	1,897.0	1,802.0
	Count	2,890	2610	2480
	Population	130,843	130843	130843

Oxfordshire has delivered on its plan to redirect resources away from long-term residential and nursing care. This is linked to the Oxfordshire Way and the Home First framework set out elsewhere in this plan. In summary we aim through a range of plans to support people at home and with access to community assets to help people maintain independence for longer and to reduce the length of stay in residential care through delayed entry to these services. We will maintain this plan in 2023-24

		2021-22 Actual	2022-23 Plan	2022-23 estimated	2023-24 Plan
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	369.5	350.2	346.5	325.8
	Numerator	481	474	469	450
	Denominator	130,189	135,361	135,361	138,108

National Condition 3

Use this section to describe how your area will meet BCF objective 2: **Provide the right care in the right place at the right time.**

Please describe the approach in your area to integrating care to support people to receive the right care in the right place at the right time, how collaborative commissioning will support this and how primary, intermediate, community and social care services are being delivered to support safe and timely discharge, including:

- ongoing arrangements to embed a home first approach and ensure that more people are discharged to their usual place of residence with appropriate support, in line with the Government's hospital discharge and community support guidance.

- How additional discharge funding is being used to deliver investment in social care and community capacity to support discharge and free up beds.

- Implementing the ministerial priority to tackle immediate pressures in delayed discharges and bring about sustained improvements in outcomes for people discharged from hospital and wider system flow.

Oxfordshire will make a step change in the delivery of Home First in 2023-25. During winter 2022-23 we have established a multi-agency Transfer of Care Hub and appointed a system lead to manage the development and implementation of the model during this period. The new model has already improved decision-making regarding choice of discharge pathways and will be extended as follows:

1. Our pathway 1 model will be transformed into a fully discharge to assess model where people will be supported at home for up to 72 hours whilst assessed for reablement, rehabilitation or domiciliary care and a plan is put in place. This involves a redesign of current services which we are developing in partnership with our independent strategic care and reablement providers. The model will be implemented in phases from July to Oct 2023 and be fully operational before the winter. In the same phase the Hospital Social Work and Home First teams will be redesigned to support the new model, with the aim that they follow people home and assess them there. Additional Discharge Funding is supporting the implementation and will be used to fund any elements that cannot be redeployed from our current model. There is a proportion of the Additional Discharge Fund which is not yet allocated and the deployment of this will be assessed as part of the learning from the phased roll out.

The new model will increase the amount of people discharged to Pathway 1 and will require increased investment in reablement and care packages and this increased capacity will be funded from the Additional Discharge Funding. Our long-term domiciliary care Live Well at Home framework has expanded significantly and delivering significantly increased capacity. During winter 2022-23 we have expanded the number of providers working into our Home

First reablement model and we will be seeking to integrate this new capacity and capability into this new D2A model.

2. We are similarly redesigning our Pathway 2 provision in 2 phases

a) in phase 1 we are recommissioning our current "short stay hub beds". These beds commissioned from nursing homes and flow through them is managed by a multi-disciplinary team led by the acute hospital discharge team. For reablement we will firstly seek to divert more people into Home First Discharge to Assess as above. Where people need a reablement bed we will move to a 7 day therapy led model of in-reach into the homes which will reduce LoS from 21-25 to 10-14 days. This increased throughput will allow us to reduce the number of beds and support the development of our Home First Discharge to Assess ethos and practice.

As part of the recommissioning of the nursing home provision we will also continue to commission discharge to assess for beds who would benefit from a nursing home stay to confirm their long-term care needs

b) the work of the transfer of care team has established "clear water" between people needing bed-based reablement and bed-based rehabilitation. In 2023-24 we will continue to assess the level of demand for rehabilitation and the specific requirements that we may need where rehab at home is not an option on discharge from acute (complex medical needs and frailty; non-weight bearing; bariatric pathway). In Q3 we will reset our ambition and plan for P2 rehab provision during 2024-25 and develop proposals for the use of that estate in step down and alternative community-based provision

3. Additionally we have identified a continuing unmet need for delirium-related support. In the short-term we have identified the opportunity to deploy the Additional Discharge Funding to purchase specialist provision from local nursing homes. However, our plan is to develop a mixed model of beds and in-reach support to people's homes. We will finalise this model during Q2 2023-24 and then proceed to implementation.

4. Additional Discharge Funding is also being used to support flow through specialist Mental Health and/or Learning Disability beds and to enable these user groups to flow more effectively through acute settings. This includes

Step down beds for people with severe mental illness

A personality disorder discharge support service

Enhanced discharge support to care homes for older people with complex presentations

Expanded MDT approaches to supporting complex discharges with more upstream planning

Housing options development for people with complex learning disability and/or autism presentations

In-reach service to support the specialist learning disability team in acute settings with effective discharge planning

National Condition 3 (cont)

Set out the rationale for your estimates of demand and capacity for intermediate care to support discharge from hospital. This should include:

- learning from 2022-23 such as
    - where number of referrals did and did not meet expectations
    - unmet demand, i.e. where a person was offered support in a less appropriate service or pathway (estimates could be used where this data is not collected)
    - patterns of referrals and impact of work to reduce demand on bedded services – e.g. improved provision of support in a person's own home, plus evidence of underutilisation or over-prescription of existing intermediate care services);
- approach to estimating demand, assumptions made and gaps in provision identified
- planned changes to your BCF plan as a result of this work.
    - where, if anywhere, have you estimated there will be gaps between the capacity and the expected demand?
    - how have estimates of capacity and demand (including gaps in capacity) been taken on board) and reflected in the wider BCF plans.

Our understanding of the demand for intermediate care, and across acute and mental health pathways, has developed both from the implementation of the Transfer of Care hub in the acute, and focussed work on delays to discharge in mental health pathways.

All acute discharges other than P0 are now routed through the Transfer of Care hub. This has radically reduced the use of bed-based and/or inappropriate pathways owing to pressure to discharge patients and has led to the development of the Home First D2A model (see previous section) and the review of our P2 reablement and social care pathways.

We have assumed a 5% increase in demand.

We have commissioned from BCF an Urgent Care Community Links service from Age UK to support people needing help on P0. The service also supports other discharges where indicated especially carers and other family members. Although the demand and capacity profile shows a slight shortfall the service can flex above contracted levels and will draw on the community resources developed as part of the Oxfordshire Way.

We have reprofiled P1 capacity across reablement, rehabilitation and social care as these are all routed by the TOC hub to Home First for deployment to our Live Well at Home strategic providers. We are stepping up the capacity within this service both to meet the expanded demand from October and to meet the redirected demand from P2 reablement beds.

We are reducing the P2 reablement capacity in line with Home First and increasing the throughput via a shorter length of stay 7 day therapy model. This change in demand profile has been mapped into P1.

We have discharge data into P2 rehabilitation from the Transfer of Care hub and LoS data in the community hospital beds. In 2023-24 we have assumed a “standstill” profile of beds and length of stay but this will be reviewed in Q3 as there may be a case to reduce demand assumptions as the Transfer of Care team continues to divert people to Home First and/or bed based reablement rather than rehabilitation.

We have mapped short-term social care capacity to demand. There is surplus capacity in terms of our Live Well at Home domiciliary care framework and residential and nursing home beds. The barriers to discharge and lengths of stay tend to be for other reasons (equipment, complex discharges and so on) than simple capacity. We will review this in Q3 and reprofile as necessary for winter and for 2425. We do anticipate in 2324 the need to buy additional nursing home capacity until we have fully implemented Home First D2A.

The demand and capacity plan for mental health discharges has been impacted by the same data outage that has impacted community intermediate care. The data also needs to be mapped onto the pathways used in acute hospital discharge and there are both language and technical differences in the resources used and destinations achieved. The data as presented is the capacity achieved in 2223 inflated by 5% and allocated pro-rata to a judgement of the mental health leads on how to map existing pathways onto the BCF definitions. There is not a way at this point of understanding how this capacity relates specifically to demand. There are delays and the plans for the deployment of the Additional Discharge Funding set out how this capacity will be improved. However at this stage the

demand and capacity are netted off. This will be reviewed during Q2 as data becomes available and the plans will be reviewed for Q3/Q4 and 202425.

National Condition 3 (cont)

Set out how BCF funded activity will support delivery of this objective, with particular reference to changes or new schemes for 2023-25 and how these services will impact on the following metrics:

- Discharge to usual place of residence

The measures set out above will support the development and delivery of improved performance against Metric 8.3. However, there is a level of risk relating to the amount of pathway change and improvement in 2023-24 and we are therefore profiling an improvement where we achieve 95% in 2024-25. We have retained as part of the Additional Discharge Funding a provision to purchase short-term interim P2 beds over the winter 2023-24 and this may-if deployed-offset the delivery of the metric, but we plan to reduce this provision in 2024-25 and to remove it entirely as soon as capacity permits.

		2022-23 Q1 Actual	2022-23 Q2 Actual	2022-23 Q3 Actual	2021-22 Q4 Plan
Percentage of people, resident in the HWB, who are discharged from acute	Quarter (%)	90.7%	91.3%	90.6%	93.0%
	Numerator	11,143	11,499	11,670	11,260

hospital to their normal place of residence (SUS data - available on the Better Care Exchange)	Denominator	12,282	12,588	12,882	12,109
		2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan
	Quarter (%)	91.0%	92.0%	92.5%	93.0%
	Numerator	11,193	11,500	11,840	11,625
	Denominator	12,300	12,500	12,800	12,500

National Condition 3 (cont)

Set out progress in implementing the High Impact Change Model for managing transfers of care, any areas for improvement identified and planned work to address these.

Oxfordshire is moving towards full maturity against the HICM with the implementation of Home First MDT, the transfer of care hub and the integrated interface between assessment and provision across NHS, social care and independent providers:

Early Discharge Planning: achieved through the Transfer of Care hub

System demand and capacity: partly achieved for discharge less so for community intermediate care demand. We have made provision in the deployment of the Additional Discharge Funding for both the IT that may improve monitoring, planning and deployment and the business intelligence that will map dependent capacity (eg where dedicated therapy might be needed to support a provider led discharge)

Multidisciplinary Discharge team working: achieved via Transfer of Care TOC hub, Home First D2A MDT and the Hub team managing flow through P2 reablement beds

Home First D2A: achieved-roll out July-Oct 2023

Flexible working patterns: partly achieved. A review of the deployment of dedicated staff teams and/or moving discharge functions to business as usual for existing teams across 7 day working is under way in Q1 and Q2 of 2324

Trusted assessment: partly achieved. We have had considerable success with an interim model in 2223 which has been welcomed by independent care providers. In the new models of care all P1 and P2 referrals will now be on a trusted assessor basis using common assessment tools and templates. The space for a dedicated trusted assessor service will be in restarts, some complex social care packages and in supporting providers working into the new pathways. This expanded service will be funded from Additional Discharge Funding and operational prior to Q3 2324

Improved Discharge to Care homes: partly achieved. We will be expanding our Care Home Support Service to deploy specialist mental health support in 2324 to improve discharge form acute and older adult mental health beds. This will be funded by Additional Discharge Funding

Housing and related pathways. Achieved for homeless people in both mental health and acute settings where we are investing in step down bed provision and the associated teams to enable people to move on to more settled accommodation and engage with health and other services. Other issues relating to housing will form part of the development of the more integrated approach across housing, technology and equipment

National Condition 3 (cont)

Please describe how you have used BCF funding, including the iBCF and ASC Discharge Fund to ensure that duties under the Care Act are being delivered?

BCF funding is supporting

Information and advice on options and self care

Assessment and care planning in the Home First Discharge to Assess and the other discharge pathways

Support for carers in terms of advice and information and also personal budgets

Support for the most complex needs including for people in crisis

Market development through the Live Well at Home Framework to deliver Home First Discharge to Assess and the recommissioning of short-term discharge to assess beds

Market Sustainability through funding of fee uplifts

Trusted Assessor to support independent providers including in self-funded arrangements

Support for workforce development and funding for the care provider body

Supporting unpaid carers

Please describe how BCF plans and BCF funded services are supporting unpaid carers, including how funding for carers breaks and implementation of Care Act duties in the NHS minimum contribution is being used to improve outcomes for unpaid carers.

In 2022/23 we have been listening to carers through workshops, surveys, storytelling and carers' voices events in shaping a new strategy. This has told us that although caring can be rewarding, carers are frequently tired, cannot easily find information that they need, have to keep retelling their story, and do not feel valued.

We have developed a strategy that is currently out for consultation. This strategy has been co-produced with 1,600 adult and young carers along with stakeholders from the County Council, Carers Oxfordshire, Rethink Mental Illness, Oxfordshire Family Support Network, Be Free Young Carers, Oxfordshire Parent Carer Forum, Age UK Oxfordshire, Dementia Oxfordshire, Oxford Health, Oxford University Hospitals, Buckinghamshire Oxfordshire and Berkshire West Integrated Care Board and Oxford City Primary Care Networks Social Prescribers.

The action plan within this strategy proposes practical steps to recognise, involve, empower and support carers of all ages. We will continue to listen to carers throughout the lifetime of the strategy and build this into our annual review of the BCF plan

The BCF funds

- Carers Oxfordshire, a partnership between the charities Action for Carers (Oxfordshire) and Rethink Mental Illness, has been commissioned by the Council to be the primary Adult Social Care service for unpaid carers 18 years and older
- Personal budgets that are available for unpaid carers to support their wellbeing

Subject to the result of the engagement our key actions in the lifetime of the BCF plan will be

Improve recording & reporting data re unpaid carers

Ensure support to carers is effective at improving their wellbeing and providing opportunities from breaks from their caring role (including access to those community services developed as part of the Oxfordshire Way)

safeguard the most vulnerable carers who need more support to look after themselves, particularly during times of change and transition

encourage and enable carers to have an active life outside their caring role, including fulfilling their education, employment, and training potential

All health providers are signed up this plan and to developing common metrics that enable us to measure impact of the strategy as well as in the BCF funded services.

Disabled Facilities Grant (DFG) and wider services

What is your strategic approach to using housing support, including DFG funding, that supports independence at home?

There is strong operational co-working around housing adaptations: the DFG pays for Housing Occupational Therapy teams around the County that work closely with housing teams and all of our Home Improvement Agency services are now either delivered directly by District Councils in a partnership or a directly commissioned service. There are also a range of district housing-BCF interfaces eg the role of Community Safety approaches in supporting integrated strengths-based assessment and care planning, and local district-led initiatives around community support as part of tenancy sustainment or around falls risk. There is an opportunity for the BCF to deepen and extend the joint working across these and other related areas (e.g. extra care housing allocation, development of move on accommodation for people in step down pathways). This work will be led by the Council and will include two aspects: the opportunities to develop assistive technology, community equipment and adaptations into a range of options to support people to stay at home led by the Council's Principal OT together with housing leads and commissioners; and a review of the wider interface of the BCF with housing to identify opportunities to increase options to deliver more integrated approaches.

This development is a key priority for 2023-24 and an acknowledgement that there is scope to improve aspects of this work. We will also seek to identify how this work might be informed by the Public Health Better Housing Better Health.

Additional information (not assured)

Have you made use of the Regulatory Reform (Housing Assistance) (England and Wales) Order 2002 (RRO) to use a portion of DFG funding for discretionary services? (Y/N)

No

If so, what is the amount that is allocated for these discretionary uses and how many districts use this funding?

Not applicable

Equality and health inequalities

How will the plan contribute to reducing health inequalities and disparities for the local population, taking account of people with protected characteristics? This should include

- Changes from previous BCF plan
- How equality impacts of the local BCF plan have been considered
- How these inequalities are being addressed through the BCF plan and BCF funded services
- Changes to local priorities related to health inequality and equality and how activities in the document will address these
- Any actions moving forward that can contribute to reducing these differences in outcomes
- How priorities and Operational Guidelines regarding health inequalities, as well as local authorities' priorities under the Equality Act and NHS actions in line with Core20PLUS5.

The current BCF plan expands Oxfordshire's focus on health inequalities in 3 key ways:

1. The Additional Discharge Funding is deployed extensively to support the most vulnerable people on discharge from specialist as well as general acute settings. Oxfordshire has purchased specialist step down beds for people living with severe mental illness where either they would benefit from bed-based reablement with specialist support during transition, and/or where they have no home to which they can return. These beds also provide a step up capacity for some people who typically will have attended ED and are not plugged into primary and community health services. The in-reach staff that support these beds work both to engage people in health services. This funding is supporting the wider homelessness pathway in 2023-24 and will form part of a wider system conversation around the role of the BCF and other plans and partners in meeting these needs from 2024-25. The BCF additionally already invests in the current homelessness MDT

We are investing in specialist mental health support to enable older people with complex needs be discharged to nursing homes where there needs can be managed in the least restrictive setting. This will support people in both mental health and acute beds.

We are investing in support for people with personality disorders who typically can get delayed in specialist mental health units In-reach service to support the specialist learning disability team in acute settings with effective discharge planning.

We are investing in integrated capacity across health, therapy, social work for people both in mental health units and learning disability/autism settings. These MDT approaches recognise the additional complexity facing these groups beyond the Home First model in successful discharges into the community.

We will improve access to longer-term housing for people with complex needs in our discharge pathways: we will fund specialist development capacity to identify housing options for people living with learning disability/autism settings; and we will work with district councils to integrate housing options for people in step down pathways who have no home.

2. The BCF through the Oxfordshire Way and Community Capacity grants are supporting the Public Health priority to improve health outcomes in the 10 most deprived wards overseen by the join Health Inequalities Forum. As noted at various points in this plan there are opportunities to map, align and integrate services and funding to improve health outcomes and the delivery of the BCF metrics for our population.

The principle focus of this work is on addressing isolation and increasing exercise to address our key challenges around mental ill-health and cardiovascular disease in our most vulnerable populations.

3. We will be working with our providers across a range of fields (support for unpaid carers, demand and capacity for community intermediate care, profiles of fallers, community capacity) to develop outcome metrics that can be mapped back to health inequalities and to the BCF metrics. This will be overseen by the Oxfordshire Health Inequalities Forum that brings together Public Health, ICB, social care, Districts and the Community providers to assure progress with plans and support decision-making on deployment of resources including BCF and ICB Inequalities Funding.