Forward View into Action

Registering interest to join the new models of care programme

Q1. Who is making the application?

(What is the entity or partnership that is applying? Interested areas may want to list wider partnerships in place, e.g. with the voluntary sector. Please include the name and contact details of a single senior person best able to field queries about the application.)

This is a system wide application by health and social care for Oxfordshire including commissioners, providers and voluntary sector organisations.

Key Contact	Rosie Rowe OCCG Head of Provider Development (Out of Hospital Care).
Telephone	07795 474432
Email	Rosie.rowe@oxfordshireccg.nhs.uk

Q2. What are you trying to do?

(Please outline your main objectives, and the principal changes you are planning to make to change the delivery of care. What will it look like for your local community and for your staff?)

Introduction

This new model of care being progressed in Oxfordshire aims to address the challenges facing primary and community care, particularly in Bicester and Witney, make maximum use of the facilities of the new hospital in Bicester, the existing Witney Hospital and facilitate further development of an outcomes based approach (OBC) as means of moving to a capitated model of allocating budgets on a locality basis.

Vanguard provides us with an opportunity to join up 3 significant pieces of work to progress our ambition for radical and transformational change across the whole system to deliver better outcomes for patients. By working as a system we want to ensure that care is co-produced with patients and carers and enable them to access the right expertise at the right time to achieve the outcomes they want.

Our plans aim to address historical problems of infrastructure, capacity and configuration of clinical services across Oxfordshire. They are also designed to impact on the challenges facing local health and social care services, including increasing demand, a growing and ageing population with increasingly complex health and social care requirements, and tight financial constraints.

Our transformation programme is described below.

Relevant Population groups

1. **Working age families;** based in new housing developments who have need for

preventive care, episodic access to primary medical care, demand for children's and young people's services and increased need psychological support. This will focus in on the current and future needs of the rapidly expanding community of Bicester Garden City with its population that is set to double over the next 16 years.

2. **Market Town Communities;** which act as a health and social care hub for a wider rural population that are geographically distant from acute hospital facilities. The Witney locality typifies this population having a mix of service families, higher than average older population, with complex needs, and pockets of urban and rural deprivation.

3. **Older Adults with Complex Care Needs;** with a need for co-ordinated care and rapid response in crisis to reduce the need for emergency and/or urgent care

4. **Adult Mental Health:** this includes those with conditions such as neuro-developmental, psychosis, mood disorders (e.g. bipolar, anxiety, depression), personality disorders and addictive behaviours.

To deliver better outcomes for all of these populations we want to join up the three core components of this transformational programme:

Transformation of Primary Care

We are looking to provide a significantly different approach to delivery of primary and community services. Our transformation plans will drive change in how:

- care is delivered within GP practices
- care is delivered collaboratively across practices working through their GP federations
- primary care interfaces with wider primary and community services, especially community pharmacy.

The aim is to take a stratified approach within primary care to managing demand based on the following three types of presentation:

1. Those where access is a priority (primarily young, self-limiting illnesses, no/few co-morbidities).
2. Those for whom continuity of care is the priority (elderly, less mobile, stable long-term conditions, co-morbidities or mental health issues)
3. Those where access and continuity are of equal priority (patients as above with unstable conditions).

To do this:

- GP's based in practices will use their advanced skills and longer (20 minute) appointments to address the needs of complex patients, especially those at end of life, with dementia or mental health problems.

- The GP Federations will organise themselves to provide Primary Care

Assessment Units in each locality that will deliver same day assessment and treatment for those requiring urgent care for episodic self-limiting illness, those with unstable complex needs and patients with a mental health or social care crisis

The units will be based in health and social care hubs co-located with other local services, including diagnostics and integrated community health and social care teams. They will be staffed by an extended primary care workforce that would include Physician Assistants, Emergency Care Practitioners and Advanced Nurse Prescribers who will:

- provide same day GP urgent appointments for episodic self-limiting illness
- manage requests for GP visits (taking account of when it is for patients to be seen their own GP)
- support patients who are experiencing a mental health or social care crisis
- provide urgent community nursing support (e.g. blocked catheters)
- deliver emergency care working closely with EMUs/virtual EMUs
- manage surges in demand by increasing/flexing medical cover

2. Implementation of an outcomes based approach through the 'Alliance', between the OUH and OHFT

Oxford University Hospitals NHS Trust and Oxford Health Foundation Trust have formed an 'alliance' acting as a single provider for the provision of urgent care for people who are:

- acutely unwell and require an acute admission and linked to a timely supported discharge
- those requiring rapid assessment , treatment and stabilisation who could be treated in an Emergency Multidisciplinary Unit, with admission to a community hospital bed
- complex elderly patients where proactive support in primary care is crucial
- elderly where advice is provided through primary care and integrated locality teams to support people to 'age well'.

Through the Alliance, working closely with primary care, we will implement a model of care that promotes rapid assessment and intervention, a reduction in bed based care and a corresponding increase in ambulatory care. The key elements include:

- unified care network across domiciliary, community hubs and acute hospitals. 'Local where possible, centralised only where necessary'.
- ambulatory care by default which is co-located, capable (24/7) with teams with plural physical, psychological and social capability.
- universal best practice where 'Comprehensive Geriatric Assessment' and an 'Enhanced Recovery approach' are prominent

This will enable us to:

- deliver effective and personalised care for older people and adults with complex health and social care needs.

- respond to rising demand whilst delivering cost effective patient outcomes within sustainable financial resources.
- enable higher levels of independence and recovery responding to rising demand enabling health and social care resources to be focused on those with greatest need
- provide care at home, or as close to home as possible, where clinically appropriate, using ambulatory multi-disciplinary care support by technology.

Our aim is to work seamlessly in partnership and at scale, including South Central Ambulance Service Foundation Trust (SCAS) who have vast experience in providing 24/7 999, 111, Patient Transport and Clinical Logistics services. Acting together to improve integrated working with paramedics, improve the delivery of patient pathways and providing alternatives to conveyance to acute hospitals.

Building on Developments in Outcomes Based Contracting in Mental Health

Oxfordshire Mental Health Partnership (OMHP) brings together Oxford Health NHS Foundation Trust (the lead contractor) with Oxfordshire Mind, Restore, Response, Elmore Community Services and Connection Floating Support. The partnership working closely with service users and carers is leading on a more flexible needs-led approach to the provision of individualised care. We aim to use the learning from this way of working to inform our wider transformation plans.

The partnerships approach provides a very different experience for service users when they need urgent help. The benefits we will incorporate in our transformational plans are:

- co-ordinated recovery focused treatment interventions as part of a single care plan with outcome measures.
- shared information so that people do not have to tell their story repeated times with shared data systems across organisations and pathways.
- joint incident reporting and learning through closer working between organisational safeguarding systems.
- pioneering innovation including recovery colleges and community care assessment centres.

3. What will it look like for your local community and for your staff?

The effect of bringing together these three strands of work will be the delivery of an aligned service offer for patients right across Oxfordshire with Primary Care leading in localities working in close partnership with community, acute and third sector providers.
Communities provision will be strengthened and patients will experience a more localised, responsive and joined up package of care with clear navigation to the most appropriate point of access and the right range of personalised health and care services to enable self care, an effective response to acute exacerbations of long

term conditions as well as ensuring that acute needs are met in a timely mannner.

A 'Triangle of Care' approach, developed by carers and staff in mental health, provides learning to improve carer engagement with acute inpatient and home treatment services to empower those most closely involved in providing support to do what is right for patients improving patient experience and satisfaction with the care they receive.

For all staff across the sector, there will be a requirement and opportunity to develop:

- Aligned care pathways supported by increased multidisciplinary working
- Collaboration with patients and their carers so that they are better enabled to make decisions about their care needs and engage actively in co-managing their conditions
- New roles that will enable professionals to work to the optimum of their skillset with the benefit of enhanced staff satisfaction, better retention and recruitment, and the creation of a flexible workforce
- Integration of IT systems and use of tele-health as an enabler for effective team-working across organisational boundaries
- Partnership working with the voluntary sector and other local services to maximise the use of local resources and expertise.

Q3. Which model(s) are you pursuing? (of the four described)

Our model is similar to the multi-specialty provider approach. However by using an outcomes based approach our model, goes beyond the four models of care described, as it enables us to move towards place based locality budgets that ensures resources are allocated to meet the greatest need.

Q4. Where have you got to?

(Please summarise the main concrete steps or achievements you have already made towards developing the new care model locally, e.g. progress made in 2014.)

Broader systems leadership

Oxfordshire is establishing system leadership approach across through its Systems Leadership Group where CCG, Local Authority, Primary Care Federation and provider CEO's meet to agree strategic direction, a Systems Resilience Group that collectively manages in year issues and pressures, and an Oxfordshire Transformation Board, chaired by the CEO of the Community and Mental Health Trust (Oxford Health), that will commission, drive and monitor key programmes of transformation across the system. This facilitates county wide partnership working based on shared responsibility and problem solving.

Development of Primary Care

A clear vision for how primary care needs to be transformed has been co-produced by the CCG with its member practices including county wide discussion and support for a new federated approach to provision of primary care. Patient groups and local third sector agencies have been consulted through locality fora and a wider

consultation with the public took place in 2014.

GP practices have analysed their population, stratifying patients with most complex needs, to better support them using enhanced care planning. Demand analysis is underway to identify the care needs of 'high consumers' of health care within GP practices to enable a more proactive, personalised care offer for these patient groups.

Future demand, driven by demographic change and population growth is also being mapped by NHS England and the Local Authority to enable us to plan services over the forthcoming years

Collaborative working has been developed through the formation of Oxfordshire Primary Care Federations as legally constituted organisations with membership from practices countywide. They bring experience in collaborating effectively to provide services and have the leadership, clinical governance structures and project management capacity to mobilise rapidly.

Detailed financial and workforce modelling have been undertaken to inform the implementation of these new models of care in the two demonstrator sites, Bicester and Witney, to enable us to spread this learning to other localities in the county.

Oxfordshire Mental Health Partnership (OHMP)

Mental health services have changed dramatically over the years and as a consequence, have experience in being at the forefront of transformation, particularly in creating greater community capacity and reducing inpatient care. The OHMP is an exciting proposal that has the capacity to make a genuine difference to service users, carers, staff and commissioners.

Based on feedback from service users and carers Oxfordshire now has:

- Locality-based Adult Mental Health Teams (AMHTs) working 24/7
- Benefit advice and employment support embedded in the AMHTs
- Housing, benefit, employment works provided in inpatient units
- Multi-agency reviews of Supported Independent Living Services (SILS) taking place
- Multi-agency complex case panels
- Agreement for outcomes-based contract with voluntary sector partners over the next five years.

This means that service users and carers experience a joined up recovery and wellbeing service designed around their individual needs with fewer hand-offs and experience of a seamless service.

Oxfordshire Integrated Care Alliance for Urgent Care

This is a transformational and viable model of care that includes proposals for greater links with the voluntary sector, greater inclusion of social care and closer working with primary care to align developments and maximise efficiency.

The Alliance is supported by agreement between the two Trusts. Work has been undertaken to align approaches and ensure there are robust governance arrangements for the new structure. There are plans in place to progress communication with stakeholders including staff, patients and other providers. There are plans for service redesign and changes to the clinical workforce, development of integrated IT and digital solutions and work to develop outcomes and evaluation of the new model.

Infrastructure

Oxfordshire has two existing successful Emergency Medical units (EMU's) in Abingdon and Witney. As part of the Alliance, two more EMU's are proposed in Banbury (Horton Hospital) and Oxford City (The John Radcliffe Hospital).

The Out of Hospital Care Network of the Oxford AHSN is working with Monitor (in partnership with Deloitte) to create an economic model that will help commissioners understanding of how acute care can be moved to an out of hospital setting without destabilising providers. NIHR Oxford CLAHRC (hosted by OHFT) and NIHR Oxford Biomedical Research Centre (hosted by OUHT) are also funding research to evaluate the impact of out of hospital acute care delivered through EMUs to identify health and social care outcomes as well as creating evidence to support ambulatory care decision making by healthcare professionals.

Q5. Where do you think you could get to by April 2016?

(Please describe the changes, realistically, that could be achieved by then.)

This is an ambitious and large scale change programme across all sectors of the Oxfordshire health and social care system.

In year one we would aim to implement a new model of primary care in the two demonstrator sites of Bicester and Witney responding to the different needs of their populations. We would aim to be providing:

- Increased access to urgent same day care
- More coordinated care through integrated primary medical and community services
- Better quality care for patients through integration of IT systems that enable multidisciplinary real time access and recording in medical records
- Longer consultations and more proactive care planning for patients with complex care needs and more immediate support when in crisis.
- GP's able to manage demand more effectively, experiencing reduced stress levels, improved morale with the development of new primary care roles making working in community settings a more attractive option
- Wider access to preventive care, with increased use of Tele Health to support self-management.
- Testing of a new role for community hospitals as locality centres for managing same day access for primary and sub-acute care.

We will share learning regarding development and implementation of this new model of care, with evaluation supported through the Academic Health Science Network. It

has the potential to form a prototype for delivering enhanced primary and community care to areas of rapid population growth (e.g.Bicester Garden City), and for effective management of demand and improved access to primary and community based care. We will be ready to adapt and implement the model in the city and the south of the county.

Relationships and behaviour change

By April 2016 the acute and community sector, coming together as a single provider through the Alliance, working with primary care will be delivering a multi-professional response to care for patients. We will have achieved agreed pathways of care that will enable primary, community and acute services to support each other in managing surges in demand for urgent care supported by increased provision of urgent care in the community.

Population stratification and outcomes development

We will have developed a clear understanding of different segments of the population. This together with evaluation of outcomes from both the patient and service perspective will be providing information that will enable us to continually shape the different levels of service offer, described in section2.

Q6. What do you want from a structured national programme?
(Aside from potential investment and recognition: i.e. what other specific support is sought?)

- Support at the national level to resolve potential blocks to service reconfiguration
- Support in developing metrics for evaluating the impact and value of the new model on the local population
- Participation in a learning set with other vanguard schemes to ensure learning is shared
- Support in developing a place based, population budget for the Bicester and Witney population groups as one of the UK's initial test sites to support a more joined approach to commissioning this model in the future.
- Funds required for double running
- PMO support to deliver a programme of this scale

We will offer the following support to the national programme:

Use of new contractual forms to support transformation and sharing learning:
There are few single agreed forms of alliance arrangements in the NHS at present, which in essence means that NHS organisations, like those in Oxfordshire, attempting to progress alliance agreements are at the forefront of using new contracting mechanisms and approaches. This provides an opportunity for us to share this learning with others

Please send the completed form to the New Care Models Team (england.fiveyearview@nhs.net) by **9 February 2015**.