SYSTEM VISION FOR
CARE CLOSER TO HOME STRATEGY 2016-2021

Oxfordshire health and social care economy is a partnership comprising: Oxfordshire CCG, Oxfordshire County Council, Oxfordshire University Hospitals Foundation Trust, Oxford Health Foundation Trust, OxFed, PML GP Federation, SEOX and Abingdon Health Federation

Our vision is that, by working together, we will enable people in Oxfordshire to access more care at or closer to home

This strategy aims to address the problems facing the Oxfordshire health and care system set out in the Transformation Board's case for change. Its ambition is to achieve a step change in developing community services and to reduce demand for hospital care. We will achieve this by developing local systems of care that bring together general practice, community health and social care, the voluntary sector and supported by specialist advice, to proactively and comprehensively manage the local population's health. Care will be integrated around patients not organisations promoting health and wellbeing, offering rapid access for urgent problems and comprehensive prevention approaches for patients and populations at risk of poor health.

STRATEGIC OBJECTIVES	OUTCOME AMBITIONS AND SUSTAINABILITY GOALS	OUR OBJECTIVES AND OUTCOME AMBITIONS WILL BE DELIVERED THROUGH THE FOLLOWING IMPROVEMENT INTERVENTIONS	OVERSEEN THROUGH THE FOLLOWING GOVERNANCE ARRANGEMENTS
To increase people's ability for self-care so that they can live well and avoid unnecessary hospital admission	Nos of people quitting smoking at 4 weeks Proportion of the eligible population receiving Health Checks Obesity – metrics to be developed *Need to add goals relating to patients with long term conditions* *Prevention work to focus on early identification of decline in frail older people*	**Improvement Intervention 1: Enhanced promotion of health and wellbeing** • Delivery of agreed Health Improvement Targets • Provide online information • Involve patients in decisions about and affecting their care in a meaningful and evidence based way to improve their ability to self-care • Increase use of telehealth and digital health apps to support self-care • Increase use of non-clinical care navigators to support people to self-care, to reduce social isolation and to enable them to live at home • Increase use of care planning to ensure that care is provided based on the individual's needs and goals • Increase access to social prescribing • Work with District Councils to support infrastructure, leisure and planning policies that will support health and wellbeing • Increase awareness of how to best use the health system in children and young people working in collaboration with schools and colleges • Promote uptake of immunisation and prevention programmes by offering them in a range of settings, targeted at those with greatest need	Increase the use of the Health & Wellbeing Board to take system wide decisions and to oversee progress in implementation. Formalise governance processes so that delivery of this strategy is effectively monitored.
To deliver fully integrated care, close to home, for the frail elderly and people with complex multi-morbidities	7 day services will be available to support discharge Enable people to live and die well at home Increase the proportion of older people with an ongoing care package supported to live at home Increase the number of people dying in their place of choice Reduction in emergency admissions – or appropriate alternative .	**Improvement Intervention 2: Achieving Integration** • Deliver front line integrated community health and social care teams underpinned by a single point of access, a single assessment process, a single integrated personal care plan (based on patient identified outcomes and choice) and care coordination • Develop a shared and owned common vision that professionals 'own' rather than hand over problems, have a 'can do' ethos, and that no single part can afford to let others fail • 7 day working in community health and social care services so that it is as easy to organise urgent care in the community at times of crisis as it is to refer to hospital • Increase in individuals holding their own personal integrated budget • Increase investment in carers and the ALERT service • Integrate care interventions around the patient, using personal care planning approaches to avoid duplication and wastage and to address the physical and mental health and psychological wellbeing • Deliver agreed End Of Life strategy, focussing on working with informal carers • Improve EOL care in the community through greater co-ordination of community palliative care and hospice services • Continue integration of Psychological Services with other community and primary health care • Provide access to community psychological medicine services for people with complex LTC • Develop the rehab and recovery services in the community *Review in light of the Alliance document around the care of people with complex comorbidities*	**AND WITH THE SUPPORT OF THE FOLLOWING ENABLERS:** Investment in management and clinical time dedicated to transformation Integrated and more effective working across the two Trusts, primary care and social care (and third sector) Changes to the infrastructure to support the development of MDT approaches that are closer to home, e.g: community hubs Consistent and effective collaboration with patient groups including Locality Forums, PPGs, Healthwatch Oxfordshire, so that the new models of care place the patient at the centre of delivery of health and social care services
To build on the successful UK model of general practice to create sustainable primary care which can offer a broader range of services at a different scale.	We will deliver a primary care service that is meeting changing expectations of GP led integration of care, achieving above the national average of people 'very satisfied' with their experience of their GP surgery We will have increased the no of people with mental and physical health problems having a positive experience of care in General Practice and the community from xx to xx by March 2020. (EA7 Outcome Ambition 6) *Is there a LTC ambition that should be included?*	**Improvement Intervention 3: Primary care development** • Build on general practice as the foundation stone of primary care to create a model of primary care that supports sustainable provision of care at the practice, cluster and locality level and that will meet patient expectations re: access, continuity and GP led integration of care around the patient • Support the development of GP federations so that practices can achieve economies of scale, can offer access to a wider range of services and can work in partnership with other providers • Work in collaboration with district councils to maximise access to CIL and S106 funding from new housing developments • Support the development of clinical leaders of primary care so they have the capacity to act as strategic partners and can lead/co-ordinate care delivery across organisational boundaries • Enable increased stratification and management of demand so that GPs are able to optimise use of their expertise, increasing use of other health practitioners either within the practice or through federated services • Support improvement of the quality of care provided in general practice, developing local quality incentive schemes that support new models of care • Increase the capacity of primary care to innovate and change at the practice level, applying new technologies to offer a wider range of routes to accessing care and advice • Increase access to more flexible appointments, including provision of longer appointments so that primary care can offer a pro-active, multi morbidity service using care planning to promote effective care and to reduce unwanted care • Test targeted initiatives for socially excluded and hard to reach groups	Increased inter-operability of IT and data infrastructure to support new models of care and to deliver real time patient level data Development of new payment models and contracting mechanisms that: - support joint working and delivery of new models of care - align clinical and financial drivers to ensure a collective approach to risks and rewards - are outcomes focussed and capitation based - rebalance funding to support a shift of care closer to home - enable a sustainable future for the local health system

		• Deliver enhanced primary medical services provision to care homes, working with interface medicine to reduce NELs	
To plan and deliver care around patients, not organisations, taking a population health based approach so that proactive care is provided tailored to the needs of the local population	We will be meeting all NHS Constitution measures sustainably by the end of this plan period, with significant improvement in the first two years. *We will reduce the carbon footprint linked to health related journeys by reducing them in Oxfordshire by xxx.* Reduction in the number of outpatient attendances Reduction in health inequalities	**Improvement Intervention 4: Development of Locality Health Campuses** • Support the development of locality health campuses offering urgent care, complex care and population analysis • Develop comprehensive prevention approaches for patients and populations at high risk of poor health (including analytics and public health expertise to support population analysis, risk stratification and demand projection to identify expected volume and type of workload) • Recognise high intensity users of secondary care services and target interventions to support these patients in the community, piloting the use of a locality virtual ward to optimise earlier discharge from hospital and to avoid hospital admissions by primary care clinicians collaborating with acute care specialists • Provide rapid access to urgent same day care through development of Urgent and Emergency Care Hubs working 24/7 across the county (MIU/OOH/primary care hub/EMU/ mental and social care crisis teams) • Optimise GP use of pathology and radiology and increase primary care access to NICE approved diagnostics, supported by federation led staff training and quality monitoring • Increase local provision of elective care where there is clinical value to be gained, using technology to increase remote access to specialist advice • Co-ordinate the care for patients with complex health needs, increasing access to specialist nurse and consultant outreach in community settings for those patients with greater needs	
To increase people's ability to access urgent care more locally when they become unwell, avoiding being admitted to hospital if appropriate	Increase in the number of patients using ambulatory care Increase in ambulance conveyance from ED to ambulatory care (specific metrics to be developed) The number of DTOCS in Oxfordshire will have reduced from xxx per 100,000 of the population to xx per 100,000 by xx	**Improvement Intervention 5: Increase use of urgent ambulatory subacute/acute approach for when people become unwell** • Increase use of urgent ambulatory subacute/acute care: a. Reduce inappropriate use of A&E by improving access to community based assessment and/or referral straight to community based services b. Review of MIU provision c. Development of urgent ambulatory care approach *(Alliance to provide details)* d. Roll out of Emergency Medical Units (EMUs) or equivalent functions • Integrate 111 and OOH service with enhanced clinical input to 111. • Increase urgent transport to locality based urgent care centres • Increase integration across all providers so that the full patient record can be seen and written into • Increase access to intermediate care and reablement support to support timely discharge from acute care and to avoid acute admissions	
To increase the capacity of the out of hospital workforce to provide care rated amongst the best nationally	*Reduction in Vacancy rates?*	**Improvement Intervention 6:Development of new workforce roles, behaviours and competencies to deliver new care pathways and effective care planning** • Create a single workforce plan which supports succession planning, the development of new work force roles and maximises training opportunities to increase the pool of domiciliary care workers, nurses and allied health professionals • Link the workforce plan to housing developments so that opportunities for key worker housing is maximised • Invest in developing the existing workforce, addressing skills, competencies and behaviours to enable primary care, community health and social care professionals to work in partnership with hospital-based specialists • Empower nursing and allied health professionals to be able to directly refer to services when appropriate and to have open access services • Increase the skill mix in primary care, including use of emergency care practitioners, testing the role of physician assistants, and increasing the role of pharmacists in general practice • Develop clinical leadership across all professions • Work with the LETB and HEE to offer training to provide staff with the more generalist skills required for effective integrated working and incentivise a shift from training in hospital environments to community settings • Develop interface medicine and the skills required to ensure an ambulatory by default approach • Develop portfolio working across practice and locality campuses to support skills development, attract more practitioners to community based roles, and widen career opportunities to retain professionals working in primary care • Maximise pharmacists' contribution to support the efficiency and effectiveness of primary care prescribing: ◦ Focussing on medicines optimisation ◦ Reducing waste ◦ Working closely with primary care to improve medicines optimisation in care homes and medicines optimisation in patients with LTC • Increase use of community pharmacists to provide minor illness advice and optometrists in supporting eye care • Support closer integration of nursing, allied health professionals, and social workers, encouraging new ways of working that cross organisational boundaries and funding multidisciplinary education and training to promote local relationships • Fund training and education for the workforce that supports revalidation and continuing professional development • Develop quality improvement skills and leadership in change management • Increase access to training in interface medicine so that people who become acutely unwell can be effectively treated in a community setting such as an Emergency Medical Unit • Change the behaviour and skills of staff working in residential and institutional care	