CARE CLOSER TO HOME STRATEGY 2016-2021

Background

This strategy has been developed by the Oxfordshire health and social care economy under the auspices of the Transformation Board, 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.

It aims to address the problems facing the Oxfordshire health and care system set out in the Transformation Board's case for change, supporting the redesign of services so that there is less dependence on hospital based care.

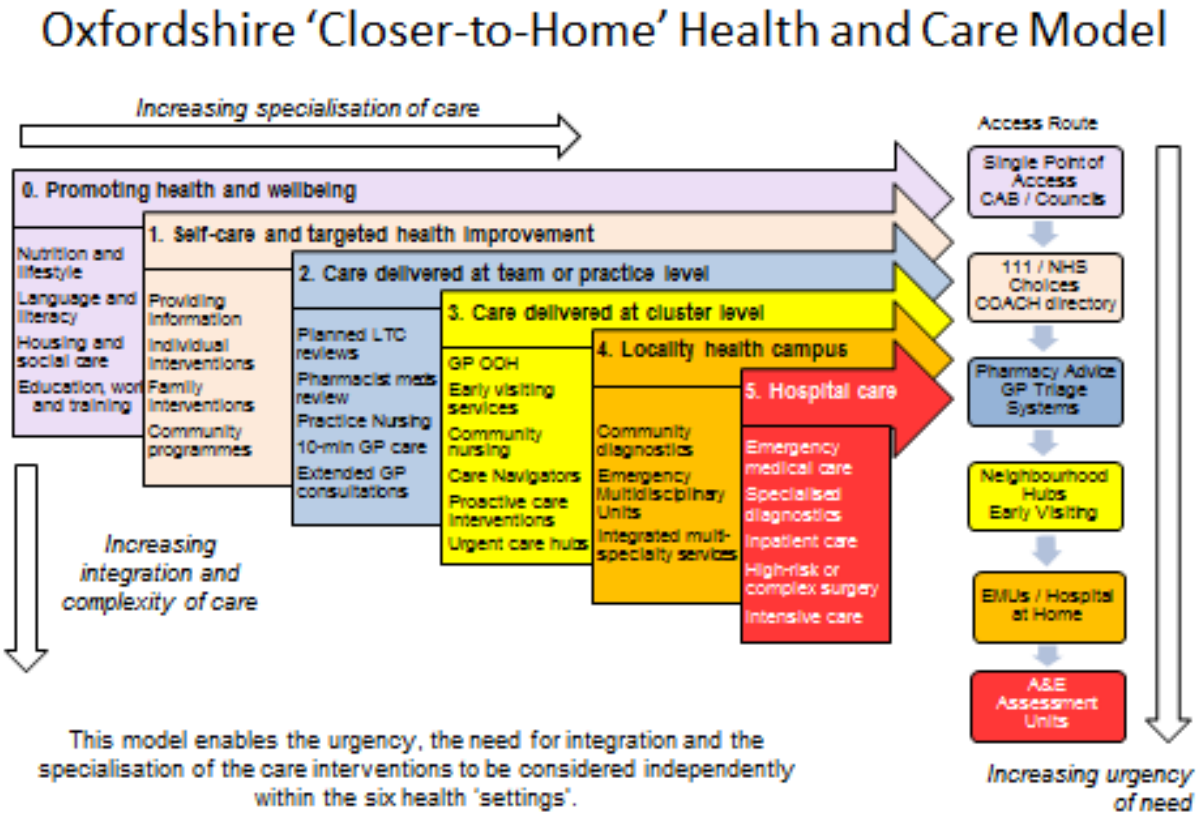
Our Vision

Our vision is that, by working together, we will enable people in Oxfordshire to be empowered to manage their care needs or to be supported in accessing necessary care at or closer to home.

We will achieve this by developing local systems of care that bring together general practice, community health and social care, the voluntary sector, supported by specialist advice, to proactively and comprehensively manage the local population's health.

Care will be integrated around people not organisations promoting health and wellbeing, offering rapid access for urgent problems and comprehensive prevention approaches for individuals and populations at risk of poor health and wellbeing outcomes.

Figure 1 illustrates how the Care Closer to Home strategy seeks to achieve a shift in activity and resources to the left of the model, away from hospital care.



STRATEGIC OBJECTIVES

1) To increase people's ability for self-care so that they can live well and avoid unnecessary hospital admission.
2) To deliver fully integrated care, close to home, for the frail elderly and people with complex multi-morbidities.
3) 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.
4) To plan and deliver care around people, not organisations, taking a population health based approach so that proactive care is provided tailored to the needs of the local population.
5) To increase people's ability to access urgent care more locally when they become unwell, avoiding being admitted to hospital if appropriate.

Objective 1: To enhance people's health and wellbeing and their ability for self-care so that they can live well and avoid unnecessary hospital admission

This will be delivered through:

- Health Improvement programmes to achieve health improvement targets
- Increased access to online information and access to information and advice at key information points e.g. post offices, parish magazines
- Involving people in decisions about and affecting their care in a meaningful and evidence based way to improve their ability to self-care
- Increased use of telehealth and digital health apps to support self-care, including earlier and more proactive use of assistive technology.
- Increased use of non-clinical care navigators to support people to self-care,to reduce social isolation and to enable them to live at home
- Increased use of care planning to ensure that care is provided based on the individual's needs and goals across health and social care, helping individuals meet their holistic needs

- Increased access to social prescribing and community information networks
- Working with District Councils to develop infrastructure, leisure and planning policies that will support health and wellbeing
- Increased awareness of how to best use the health system in children and young people working in collaboration with schools and colleges
- Promoting uptake of immunisation and prevention programmes by offering them in a range of settings, targeted at those with greatest need
- Promoting early identification of decline in frail older people
- Promoting increased fitness levels in people aged 40-60
- Working with individuals and their informal carers to enable them to be their own experts and managing their care and health budgets to meet their needs.

Progress will be measured by:

- Increase in the % of people are able to access their own records should they wish to do so.
- GP Patient survey shows improved results for people reporting their ability to self-care.
- Increase in the number of people quitting smoking at 4 weeks.
- Reduction in obesity – metrics to be developed.
- Reduction in people experiencing mental health crisis.
- Increase in the take up of screening and vaccinations.

Objective 2: To deliver fully integrated care, close to home, for the frail elderly and people with complex multi-morbidities

This will be delivered through:

- Integrated and more effective working across acute and community health services and between primary care, community health and social care and third sector providers
- Further develop front line integrated community health and social care teams which offer a fully integrated service with:
    - a single point of access
    - a single assessment process
    - a single integrated personal care plan (based on patient identified outcomes and choice)
    - education and training on how to manage their long term conditions
    - person held notes
    - a carer's support plan
    - care co-ordinated to address physical and mental health and psychological wellbeing
- Provision of a good e-marketplace so people who are funding their own care can arrange person centred solutions for their care needs
- Partnership working with Housing to access housing and improve home environments that support the individual's independence.
- Ensuring that housing options are available that meet supported living needs e.g. Extra Care Housing.
- Encouraging take up of statutory benefits, focusing on postcodes of poor take up, to take people out of the poverty trap and maximise use of Warm Front. Increasing the number of people holding their own personal integrated budget
- Continuing to integrate reablement services across health and social care
- Developing 7 day working across all sectors, with a particular focus on services in the community that provide urgent response at times of crisis
- Increasing information, advice, guidance and support for informal carers to increase their capacity to continue to do their role

- Increasing the use of technology, assistive equipment, managed adaptation to the home to support people to remain in their own homes
- Increasing timely access to transport and increase transport options delivered by community volunteers
- Delivering agreed End Of Life strategy and improve the coordination of care for people at that time across all sectors
- Improving End Of Life care in the community through greater co-ordination of community palliative care and hospice services
- Continuing integration of Psychological Services with other community and primary health care, including people with dementia.

Progress will be measured by:

- 7 day services will be available to support discharge
- All people who would benefit from a care plan will have one if appropriate
- Increase the proportion of older people with an ongoing care package supported to live at home where this is appropriate
- Increase the number of people dying in their place of choice
- Reduction in emergency attendances and admissions for people with long term conditions
- Reduction in the duplication of assessment and treatment - or appropriate alternative.

Objective 3: To create sustainable primary care which can offer a broader range of services at a different scale.

This will be delivered through

- Building 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 people's expectations re: access, continuity and GP led integration of care around the individual.

- Effective integration of primary care with community health and social care teams to provide person centric care
- Reviewing how social prescribing and community networks can support GP surgeries
- Supporting 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
- Ensuring the Oxfordshire Locality Forums and other patient or user groups are involved in service developments.
- Working in collaboration with district councils to maximise access to CIL and S106 funding from new housing developments
- Working with District Council housing teams to maximise take up and pro-active usage of Disabilities Facilities Grant
- Enabling 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
- Utilising predictive risk modelling incorporating social care data to identify and enable targeted interventions to maximum benefit
- Supporting improvement of the quality of care provided in general practice, developing local quality incentive schemes that support new models of care
- Increasing 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. This includes evaluating the use of technology and user support groups e.g. for newly diagnosed long term conditions , eLearning and linkage to government health support portals
- Increasing 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.
- Testing targeted initiatives for socially excluded and hard to reach groups
- Achieving closer working with the fire service, police and other welfare agencies

- Delivering enhanced primary medical services provision to care homes, working with interface medicine to reduce unplanned admissions to hospital.

Progress will be measured by:

- Achieving above the national average of people 'very satisfied' with their experience of their GP surgery
- Reduction in the variation of outcomes for people with long term conditions across primary care in Oxfordshire
- Reduction in medication errors, whether reported by patients or professionals
- Reduction in attendances at A&E for primary care conditions

Outcome 4: To plan and deliver care around people, not organisations, taking a population based approach so that proactive care is provided tailored to the needs of local populations

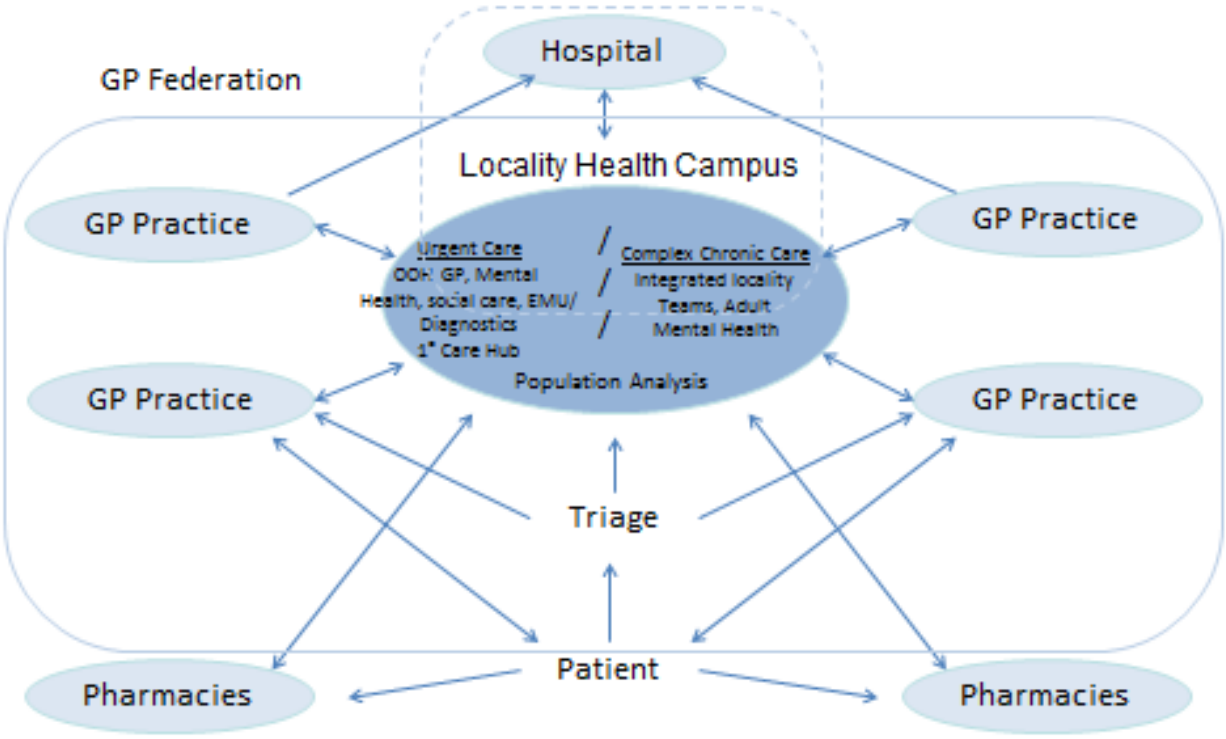
This will be delivered through:

- Supporting the development of locality health campuses offering urgent care and proactive complex care
- Developing comprehensive prevention approaches for people 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)
- Recognising high intensity users of secondary care services and target interventions to support these people in the community, piloting the use of a locality virtual ward to optimise earlier discharge from hospital and to avoid hospital admissions by multi-disciplinary teams collaborating with acute care specialists
- Publicising the support available re: advice, guidance and information online and direct access to self-assessment for assistive equipment. Inform the

public about assessment clinics for mobility and assistive equipment, social care or housing needs

- Providing 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)
- Optimising GP use of pathology and radiology and increasing primary care access to NICE approved diagnostics, supported by staff training and quality monitoring
- Increasing local provision of elective care where there is clinical value to be gained, using technology to increase remote access to specialist advice
- Co-ordinating the care for people with complex health needs, increasing access to specialist nurse and consultant outreach in community settings for those people with greater needs. Health and social care organisations to work together to provide unified services within communities to prevent hand offs between services.
- Development of clinical leadership skills within primary care, community health and social care so they have the capacity to act as strategic partners and can lead/co-ordinate care delivery across organisational boundaries in localities and practice clusters.

Figure 2 illustrates how Locality Health Campuses can be developed to deliver this population based approach.



Progress will be measured by:

- All NHS Constitution measures will be met sustainably by the end of this plan period, with significant improvement in the first two years.
- Reduction in the number of hospital based outpatient attendances
- Increase in diagnostics taking place in local communities/outside hospital settings
- Reduction in health inequalities.

Objective 5: To increase people's ability to access urgent care more locally when they become unwell, using urgent ambulatory subacute/acute approaches to care to avoid admission to hospital if appropriate.

This will be delivered through:

- Increasing 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. Further development of urgent ambulatory care approaches
    d. Increase access to Emergency Medical Units (EMUs) or equivalent functions
    e. Increase access to appropriate clinical decision support from specialist care to enable people to remain being cared for in the community
    f. Early referral to social care so eligible supports can be accessed without delay
- Integrating 111 and OOH service with enhanced clinical input to 111.
- Increasing urgent transport to locality based urgent care centres
- Increasing integration of information across all providers so that the full patient record can be seen and written into, preferably by the individual and their carers too.
- Developing skills in interface medicine so that practices can access more specialist gerontology advice at a cluster or locality level
- Increasing access to intermediate care and reablement support as part of a integrated assessment service with Adult Social Care to support timely discharge from acute care and to avoid acute admissions
- Further develop necessary decision support processes for clinicians in community settings to enable people, where clinically appropriate, to avoid conveyance and/or admission.

Progress will be measured by:

- Increase in the number of people using ambulatory care
- Increase in conveyance from the Emergency Department to ambulatory care (specific metrics to be developed)

- Reducing the number of Delayed Transfers of Care in Oxfordshire from xxx per 100,000 of the population in 2016 to xx per 100,000 by xx
- Further develop necessary decision support processes for clinicians in community setting to enable people, where clinically appropriate, to avoid conveyance and /or admission.

KEY ENABLERS

Delivery of these strategic objectives are dependent on the following key enablers, which are being taken forward as separate system wide workstreams by the Transformation Board:

Public Engagement: : Consistent and effective collaboration with patient groups including Locality Forums, PPGs, Healthwatch Oxfordshire, so that the new models of care place people at the centre of delivery of health and social care services.

Workforce Development: :Development of new workforce roles, behaviours and competencies to deliver new care pathways, effective care planning, new cultures and behaviours - see system wide workforce plan being developed for the Transformation Board.

Interoperability of IT: Development of fewer systems and interoperable IT systems which support coordination of care and the ability of people to hold their own personal health record – see system wide IT plan being developed for the Transformation Board.

Estates: Provision of an appropriate estates infrastructure to support increased care in the community – see systems wide estates plan being developed for the Transformation Board.

Governance: Agree and share protocols and policies so all services and staff are functioning to deliver the same quality of services. Allow for individual needs and variation so we can deliver personalised services, provided there are legal and no safeguarding issues.

Financing: 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 focused
- rebalance funding to support a shift of care closer to home
- enable a sustainable future for the local health system

Delivery of the Strategy

Delivery of the strategic objectives of the Care Closer to Home strategy will be taken forward by the work of the Transformation Board, in particular the primary care, long term conditions and frail elderly work stream. It will inform the Single Transformation Plan being developed by Oxfordshire and will form part of the public engagement activity planned for 2016.

Rosie Rowe
OCCG, Head of Provider Development (Out of Hospital Care)
4 April 2016