Oxford Health
NHS Foundation Trust

Community Services Strategic Framework 2021

Executive Summary

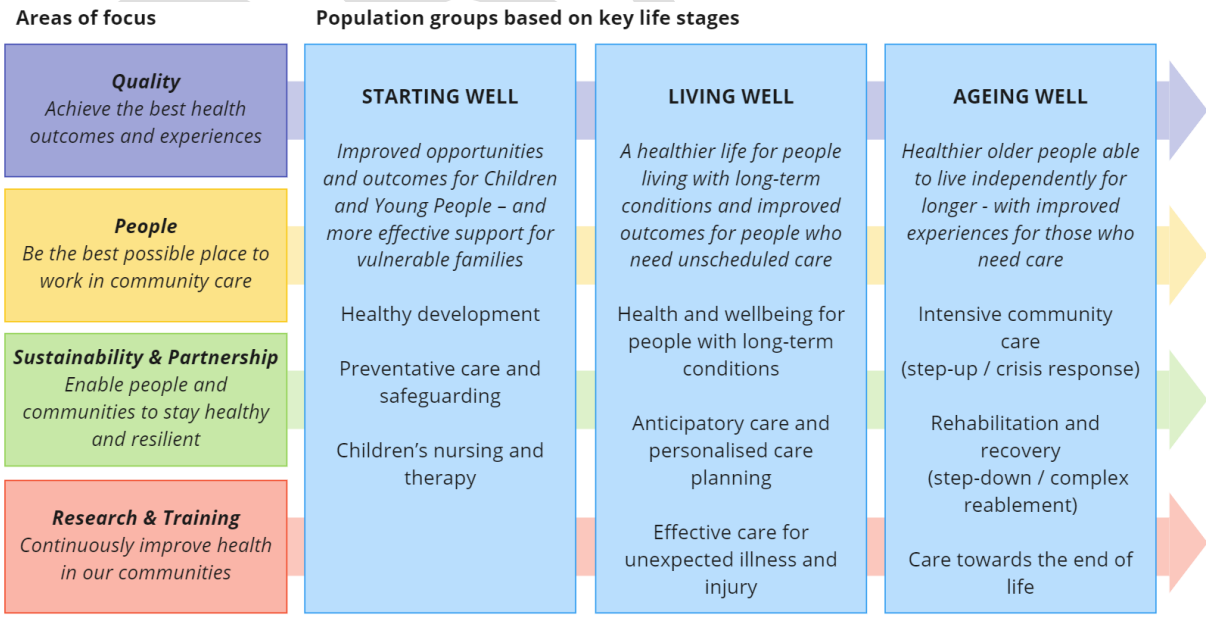
Oxford Health NHS Foundation Trust (OHFT) provides the majority of non-practice-based primary care and community health services for the population of Oxfordshire. Services are delivered in a range of community, inpatient and educational settings as well as people's homes.

Key challenges identified within Community Services include:

- The breadth of services delivered and relative lack of focus on this area in contrast to other parts of the system
- Comparatively limited funding based around block contracts and the impact of the COVID-19 pandemic
- Workforce shortages in key areas and the high cost of living in Oxfordshire
- Patient feedback that access to services can be slow and disjointed
- Variation in accessibility of services and levels of deprivation across the County
- Increased numbers of troubled families and children in the care of the local authority
- Increased proportion of older adults receiving a social care service at home

This document outlines the strategic framework for community services which is shaped by both the NHS long term plan and local plans including the Joint Health and Wellbeing Strategy for Oxfordshire. Taking an approach based on population need the strategy will be based around three life stages; start well, live well and age well.

Each life stage will be built around four pillars of particular relevance to improving community health outcomes, which map closely to Oxford Health's Trust strategy and the NHS long-term plan; Quality, Our people, Prevention and sustainability, Continuous improvement (research and training):



Delivery of the strategy will be shaped by engagement with key stakeholders and local communities to ensure it meets the needs of patients across Oxfordshire. Data to inform this engagement will be drawn from the supporting data compendium (available shortly).

Contents

A. Background and context

An introduction to community services in Oxfordshire

Each year, community health services across the UK provide around 100 million patient contacts and account for around £10 billion of the NHS budget. (Kings Fund, 2020) As a sector, they employ 20% of the total NHS workforce. In Oxfordshire, the annual budget for all community services is around £100 million.

The sector is very diverse and provides care to people of all ages and backgrounds. This includes services for people living with long-term health and care needs – such as district nursing and palliative care, services for people requiring rehabilitation and community hospital care, as well health promotion and safeguarding services for the younger generation – such as school nursing and health visiting.

Community services play a key role in keeping people well, treating urgent health problems, responding to acute illness and managing long-term conditions, with a focus on supporting people and families to live independently in their own homes and communities. As such, they are central to the future of the Oxfordshire health and care system.

The NHS long-term plan sets out ambitions to increase "out-of-hospital" care and dissolve the historic divide between sectors of the health system. The NHS is also committed to increasing the share of the healthcare budget for primary and community care services, with a plan to boost annual spending by £4.5 billion by 2023/4.

People with multiple, complex health needs, who depend on many health and social care services, will almost always be having regular contact with community services. Given their generalist and holistic nature, community services tend to work closely with other parts of the health and care system, such as GP practices, hospitals, pharmacies, hospices and care homes – to name but a few.

The increasing numbers of people living with long-term conditions means that more people are likely to need support from community health services in the future. There is evidence that the financial and workforce pressures are compromising the availability and quality of care (Kings Fund, 2020). Unless this is addressed, there is a risk that growing numbers of people will be left without the care and support they need. This is particularly concerning due to the high level of vulnerability of many people receiving community services.

Scope

There are a wide range of community health services available to the population of Oxfordshire. These are provided in a range of primary care, community, educational and inpatient settings as well as in people's homes. Existing community services in Oxfordshire that fall within the scope of this strategy include:

Type of care provision	**Current service or facility**
Primary Care	Urgent out-of-hours GP clinics and home visiting services
	Homeless GP services (Luther Street Medical Centre)
Urgent Ambulatory Care	Emergency Multidisciplinary Units (EMU) Abingdon & Witney
	First Aid Units (FAU) Bicester and Chipping Norton CHs (Wallingford FAU is provided by the GP surgery)
	Minor Injuries Units (MIU), Abingdon & Witney Hospitals
	Rapid Access Care Unit (RACU), Townlands Hospital, Henley
	Rapid Assessment Unit (RAU), Horton, Banbury
Urgent Care at Home	Hospital @ Home - South Oxfordshire
	EMU outreach
	Ageing Well 2-hr urgent community response
Reablement and Rehabilitation	Discharge-to-assess pathway 2
	Complex Care Community Service (CH discharges)
	Home First pilot
EMU short-stay beds ('step-up')	Abingdon (Abbey)
	Witney (Wenrisc and Linfoot)
General community Inpatient beds ('step-down')	Abingdon (Abbey)
	Bicester
	Oxford City
	Wallingford
	[Wantage - temporarily closed]
	Witney (Wenrisc and Linfoot)
Specialist rehabilitation Care Home support	Oxfordshire Stroke Rehabilitation Unit (OSRU), Abingdon
	Care Home Support Service (residential, nursing, LD, MH)
	Enhanced Health in Care Homes (weekly MDT)
Community – generalist nursing and therapy	Community & PCN MDTs
	District Nursing
	Community Therapy Services
	End of Life Care
	Falls Prevention (and post-covid rehab)
	Nutrition & Dietetics
	Safeguarding (adults)
Community – specialist nursing and therapy	Adult Speech & Language
	Bladder & Bowel
	Chronic Fatigue & ME service (and post-covid rehab)
	Dementia and Memory
	Diabetes Community Service
	Eating Disorders
	Heart Failure
	Physical Disability Physio
	Podiatry
	Respiratory (and post-covid rehab)
	Tissue Viability Service
Children's services	Children's Community Nursing
	Children's Therapy Services

	Family Nurse Partnership
	Health Visiting Service
	Phoenix Team (Looked After Children)
	Safeguarding (children)
	School Health Nursing Service
Other services provided by Oxford Health	Continuing Healthcare (Oxfordshire and Buckinghamshire)
	Community Health Promotion
	Outpatient nursing and admin support at Community Hospitals
	Single Point of Access
Examples of services provided by other providers	Musculoskeletal Physiotherapy (Healthshare)
	Hospital @ Home - North Oxfordshire (PML)
	Acute Hospital @ Home - Oxford City (OUHFT)

About Oxford Health NHS Foundation Trust

Oxford Health NHS Foundation Trust (OHFT) provides the majority of non-GP based community health services for the population of Oxfordshire, delivered in a range of community, inpatient and educational settings as well as people's private homes and care homes.

The Trust delivers inpatient rehabilitation and sub-acute medical care across eight wards at Community Hospital six sites across Oxfordshire. These sites, which vary considerably in terms of clinical capability and infrastructure to support and the bed stock, range in scale and capacity from 12-50 beds. Some have ambulatory care functions enabling direct admission from the community while others are more focused upon rehabilitation with bed-based care for step down patients following a period of acute inpatient care.

OHFT also runs primary care services including GP out of hours services across Oxfordshire and a practice in Oxford City for the homeless population.

The Trust is a large regional provider of mental health teams and offers a range of specialist healthcare services in community and inpatient settings across the geographic areas of Milton Keynes, Buckinghamshire, Oxfordshire, Wiltshire and BaNES. Additionally, the trust provides forensic mental health and eating disorder services across a wider geographical area including patients in Berkshire, the wider Thames Valley and Wales.

The Trust took over the community and inpatient services for people with a learning disability in Oxfordshire which had previously been run by Southern Health NHS FT, including the Evenlode medium secure inpatient service.

The Trust operates a total of 562 inpatient beds over 34 sites and has 16 registered locations. It had a total income for the 2018/19 year of £347.6 million and employed a total of 6761 (4825 WTE) staff members. As a foundation trust it is also regulated by NHSE&I.

Other providers of services in community settings

In its 2019 report, CQC identified the following service providers in Oxfordshire:

- 60 active residential care homes
- 74 active nursing care homes
- 113 active domiciliary care agencies

Reablement services and some specialist nursing services are provided by Oxford University Hospitals NHS Foundation Trust (OUHFT). OUHFT is the main acute and planned care provider in the county. 92% of hospital admissions (elective and non-elective) of people of all ages living in Oxfordshire are to OUHFT. Admissions from Oxfordshire made up 73% of the Trust's total admission activity.

69 Practices provide general medical (GP) services to Oxfordshire residents in 2020, according to OCCG data. These have organised into 19 Primary Care Networks, covering the county's population.

Some community services are also provided by private providers commissioned by OCCG:

- Principal Medical Limited (PML) – provides NHS Hospital at Home services in the north of the county
- Healthshare – provides NHS MSK physiotherapy services at community sites across Oxfordshire

The Third Sector also provides a range of important community services to residents in Oxfordshire, including:

- AgeUK – UK's largest charity providing support for older people
- Order of St Johns Care Trust – not-for-profit care organisation working solely to provide high quality care for older people
- Alzheimer's society – providing support to those living with Alzheimer's and those caring for them
- Dementia Oxfordshire – specialist dementia services, available free to people living with dementia and their families living in Oxfordshire
- Daybreak Oxford – Dementia support and day clubs in Oxfordshire
- Guideposts – work to ensure that people can be connected to their community and achieve their potential – regardless of circumstances.
- Stroke association – helping people rebuild their lives after a stroke
- Maggie's cancer care – providing long term support for those with cancer
- Macmillan cancer support - specialist health care, information and financial support for people affected by cancer
- Sobell house – Providing palliative and end of life care for those with cancer
- Headway – long term support to those with brain injury
- Multiple Sclerosis society – support for those with multiple sclerosis
- Parkinson's UK – support people with Parkinson's, their families, friends and carers, across the UK
- Autism family support - support the development and wellbeing of children and young adults on the autism spectrum, and their families

- Farm ability – farm-based programmes where people can engage in purposeful, outdoor activities that improve physical health and well-being, foster a sense of community, and allow the development and strengthening of skills and abilities
- Yellow submarine - working with young people in community settings from the age of 11 onwards, to build their social skills, confidence, independence and ultimately their employability. At the same time, we are supporting families and carers with respite.
- Mencap - Services such as group holidays, evening clubs and fundraising for those with learning disabilities
- Ways and means trust – Work based learning for adults with learning, mental and physical disabilities
- Brandon Trust- enable children, young people and adults with learning disabilities and autism to live life in the way they choose
- ADHD Oxfordshire – Understanding and support for people affected by ADHD
- Peeple – charity supporting parents with children's learning

Urgent and ambulatory care

Urgent medical care in Oxfordshire is provided by:

- Accident and Emergency departments of the John Radcliffe Hospital in Oxford and Horton Hospital in Banbury (Oxford University Hospitals NHS Trust)
- Minor Injuries Unit (MIU) in Henley, Witney and Abingdon (Oxford Health NHS FT).
- MIUs have X Ray facilities and are for injuries, such as deep cuts, eye injuries, broken bones, severe sprains, minor head injury, minor burns and scalds
- First Aid Unit (FAU) Chipping Norton, Wallingford and Bicester (Oxford Health NHS FT). FAUs are also for minor injuries but do not have X Ray facilities

In addition, GPs can refer Oxfordshire patients to:

- Emergency Multidisciplinary Units (EMU) providing subacute care based at Abingdon and Witney community hospitals (Oxford Health NHS FT)
- Rapid Access Care Unit (RACU) for ambulatory care, Townlands Hospital Henley (Oxford Health NHS FT)
- Hospital at Home services

B. Summary of current challenges

Since the advent of the NHS, community services have undergone frequent structural reorganisations, resulting in a range of provider types and sizes in existence today. A main provider is often responsible for delivering most of the community services in a geographical area, but often work alongside a host of other providers offering smaller scale or specific services.

The main providers include a range of NHS trusts – this includes trusts providing primary and community care alone as well as combined community and mental health and/or acute trusts. It has been estimated that NHS providers hold around half of the total value of community service contracts, with the rest provided by private providers, GP practices/Primary Care Networks, community interest companies, local authorities, pharmacies and charities/social enterprises (Gershlick and Firth, 2017).

The commissioning of services in many areas is complex and often fragmented. Clinical commissioning groups (CCGs) commission most adult community health services, while local authorities usually commission children's 0–19 services (e.g. health visiting, school nursing) and public health services (e.g. alcohol and drug services and sexual health). NHS England and Improvement is responsible for commissioning some health services delivered in the community, including dentistry, offender health, immunisations and national screening programmes.

The King's Fund found that trusts providing community services are, on average, commissioned by more than five different organisations (NHS Providers, 2018), and CCGs hold an average of 50 separate community service contracts (Gershlick and Firth, 2017). Services also tend to be retendered on a more regular basis than those in other parts of the NHS (Kings Fund, 2020).

The following pages highlight some of the key challenges facing community health services that apply in Oxfordshire.

Public and political profile

Community health services are often hard to define, can vary in scope and specification from place-to-place and tend to be less visible to the public and media than hospital-based services. As a result, they are often given less focus by policymakers and health service leaders and are often less well understood by commissioners and healthcare staff compared to other parts of the system.

The limited data available locally and nationally on community service activity, quality, outcomes and spending has previously made it difficult to make the case for their impact and value, particularly when competing for limited funding with other parts of the system that have better defined and resourced data collection and analysis processes in place.

Funding

It is estimated that each year around £10 billion of the NHS budget is spent on community services. Over the past decade, most community service budgets have remained static or fallen despite significantly growing demand as the population ages and there is increasing focus on disease prevention and safeguarding. In a survey by NHS Providers in 2018/19, more than half of trusts reported that their funding for community services had decreased from previous years. Where additional funding has been provided, it is usually based on a presumption that it will support a reduction in hospital inpatient care.

As a rule, community services are funded through block contracts, where payment is fixed and not based on activity. They are usually specified in local contractual arrangements and tend to not be linked directly to national targets (with some exceptions, such as Ageing Well).

It is not yet clear how the £4.5 billion investment in primary care and community health services announced in the NHS long-term plan will be allocated and what the expected outcomes will be – or how this ambition will be affected by the COVID-19 pandemic.

Within Oxfordshire, the OHFT Community Services directorate has a budget of almost £100m. Funding is largely from the Oxfordshire clinical commissioning group (OCCG) but elements of the service, particularly in the area of children's services are joint commissioned between the OCCG and Oxfordshire County Council.

Workforce

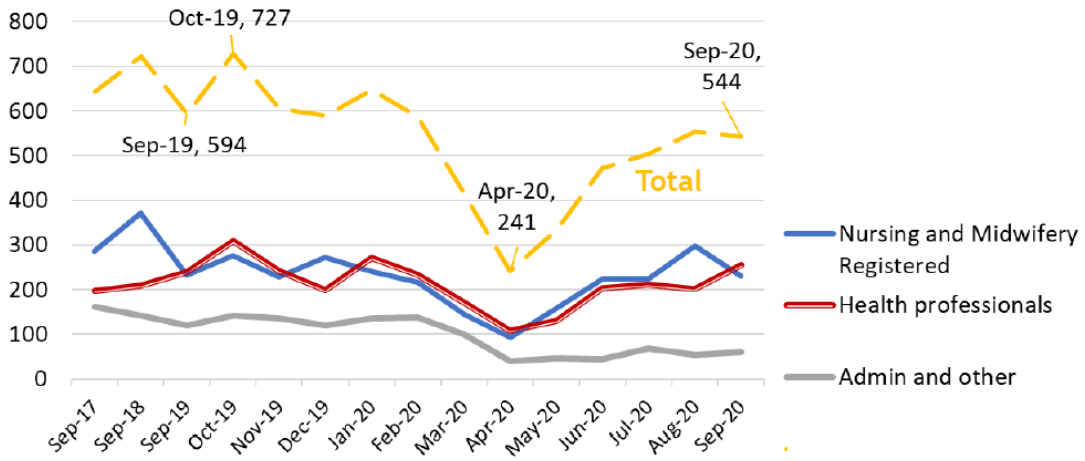
As with other sectors in the NHS, there are significant shortages in key parts of the workforce which present ongoing challenges to the sustainable provision of community services.

Nurse workforce challenges are greater in community services than other healthcare sectors. Between 2010-18, the total number of nurses working in NHS community health services reduced by 14% whereas the number in adult acute care settings increased by 9 % over the same period.

As reported by the King's Fund, pressures are particularly concerning in the number of qualified district nurses, which fell by 42% between 2010 and 2018 (Based on figures reported in NHS workforce statistics from September 2010 and September 2018, by staff group, area and level). Between 2010 and 2018, the number of community learning disabilities nurses employed by the NHS fell by 23% and the number of school nurses fell by a quarter.

Between 2010 and 2015, the number of health visitors increased in response to a drive by the Government, but this was not maintained and numbers have since fallen by 23%.

The advertising of roles has been noticeably impacted by the COVID-19 pandemic in 2020 although has since increased. This is shown within the number of advertised vacancy full time equivalents in Oxfordshire Clinical Commissioning Group, Oxford University Hospitals NHS FT and Oxford Health NHS FT (2017-20):



Source: Oxfordshire JSNA 2020

Across OHFT community services there are over 2000 staff. As at December 2020 the directorate was carrying a vacancy rate of nearly 8%. The areas with the highest vacancy rates included Associate Trainee nurses with a 27% vacancy rate, District Nurses with a 13% vacancy rate and health visitors with 12% vacancies.

House prices and cost of living

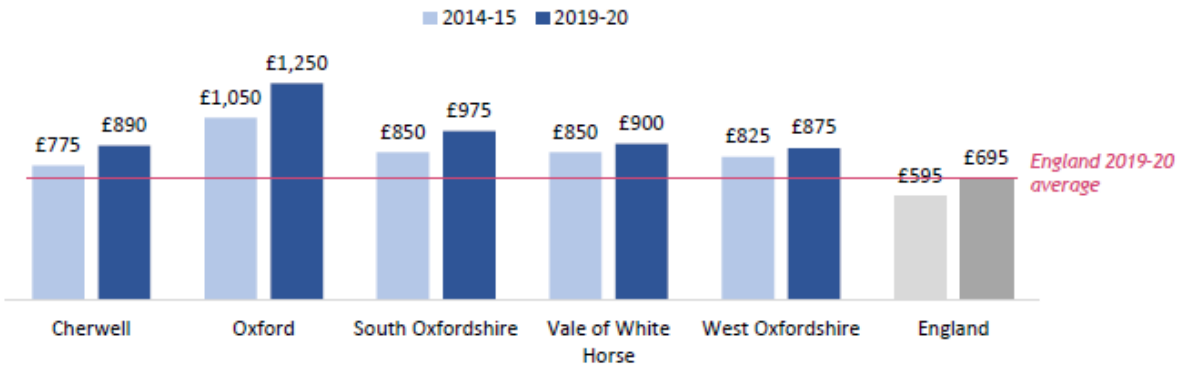
The ratio of the cheapest market housing (lower quartile) to lower earnings in Oxfordshire was 11.47 in 2018, remaining much less affordable than the England average (7.29). All districts in Oxfordshire had a lower quartile affordability ratio which was over 11 times lower earnings. The ration of lower quartile house prices to lower quartile gross annual (where available) workplace-based earnings 2014-19:

	2014	2015	2016	2017	2018	2019
Cherwell	9.45	10.21	11.14	*10.51*	11.14	11.05
Oxford	10.41	*11.36*	12.23	12.17	12.07	11.91
South Oxfordshire	10.97	*11.00*	12.67	13.00	13.93	13.31
Vale of White Horse	8.83	9.45	10.27	10.88	11.27	10.56
West Oxfordshire	*9.97*	10.15	12.52	12.56	12.54	12.01
Oxfordshire	9.64	10.14	11.12	11.40	11.47	11.22
England	6.91	7.11	7.16	7.26	7.29	7.27

Source: Oxfordshire JSNA 2020

ONS House prices to workplace earnings ratio

As of 2018-19 the median (mid-point) private rent for a 2 bed property in Oxfordshire was £953, well above the average for the South East (£875) and England (£675). In Oxford the median was £1,200 per month, 21% higher than in 2013-14.



Valuation Office Agency Private rental market summary statistics

Patient experience of services

In 2019, Healthwatch Oxfordshire gathered the views of 155 people on their experience of services across the county. This included 121 respondents to a general NHS Long Term Plan questionnaire, 20 respondents to a Long-Term Conditions questionnaire, and 14 participants in two focus groups.

People value health professionals who listen, give options, answer questions, have a caring manner. 90% of Oxfordshire respondents said it was 'very important' that professionals listen to them when they speak to them about their health concerns.

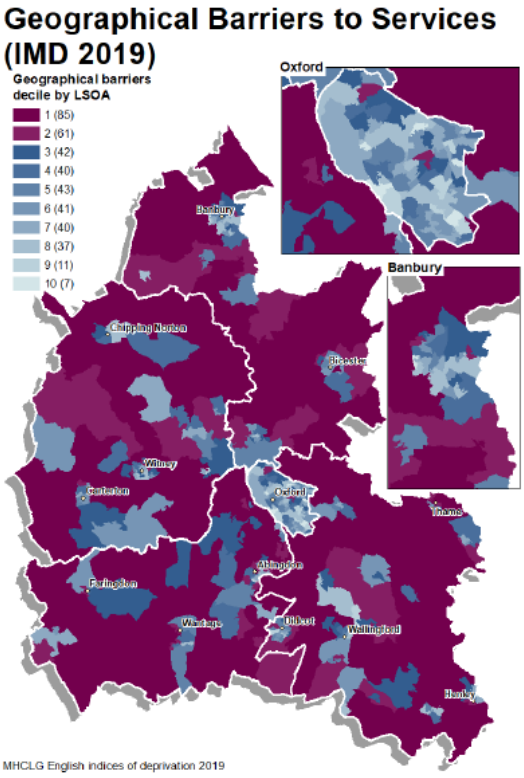
Access to healthcare

- 86% of Oxfordshire respondents said it was 'very important' to access help and treatment when needed.
- 55% of people with a specific condition said their wait for an initial assessment or diagnosis was 'slow' or 'very slow'.
- People commented on the need for joined-up care, and communication throughout the system.
- Oxfordshire residents expressed concern that service development is not keeping up with housing development.
- Transport to local services was seen as a problem in areas without public transport.
- Those with long term conditions valued continuity of care, communication across the system, and being supported with information and knowledge to manage their condition.

Accessibility of services

Areas ranked poorly on geographical access to services (within worst 10%) include:

- 21% of the total population
- 27,600 (21%) people aged 0-15
- 30,100 (24%) people aged 65+ and
- 4,000 (23%) people aged 85+



Source: Oxfordshire JSNA 2020

English indices of deprivation 2019, MCLG

According to the national ONS data on internet use:

- In the 65 to 74 age group increasing from 52% in 2011 to 83% in 2019
- In those aged 75+ increasing from 20% in 2011 to 47% in 2019
- 18% of disabled adults had never used the internet in 2019, down from 20% in 2018.

Based on these findings, it is estimated that 36,600 older people (aged 65+) living in Oxfordshire have never used the internet.

Deprivation and poverty

In 2019 Oxfordshire was ranked the 10th least deprived of 151 upper tier local authorities in England (IMD 2019). However, within this context there continue to be a number of areas which experience significant deprivation. Oxfordshire also had 1 out of 407 Lower Super Output Areas (LSOAs) ranked within the 10% most deprived areas nationally, part of Northfield Brook ward, south east Oxford. A further 16 areas were ranked in the 20% most deprived areas nationally, 9 in Oxford City, 6 in Banbury and 1 in Abingdon.

According to the 2019 Income Deprivation Affecting Children Index (IDACI) there was a total of 11,990 children in poverty in Oxfordshire. 4 areas of Oxfordshire were in the most deprived 10% nationally, down from 7 areas ranked as most deprived in 2015. The most deprived areas on the IDACI 2019, were in parts of Banbury Ruscote, Blackbird Leys, Littlemore and Rose Hill & Iffley wards.

According to the 2019 Income Deprivation Affecting Older People Index (IDAOPI) there was a total of 11,725 older people in poverty in Oxfordshire. 4 areas of Oxfordshire were in the most deprived 10% nationally, up from 1 area ranked as most deprived in 2015. The most deprived areas on the IDAOPI 2019, were in parts of Banbury Grimsbury & Hightown ward and in Carfax, Rose Hill & Iffley and St. Clement's.

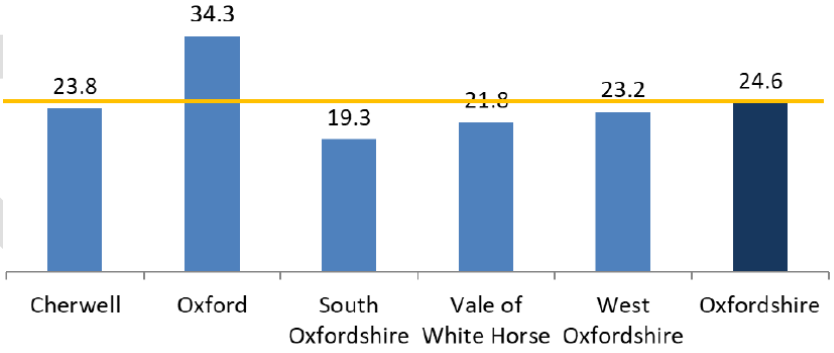
Safeguarding

As at the end of March 2019 there were 6,779 referrals to child social care in Oxfordshire related to 6,177 children. This was a reduction in the number and rate per population compared with the previous year (6,814 referrals and 6,326 children). A relatively high proportion of referrals resulted in no further action (17% in Oxfordshire compared with 8% nationally).

The number of children on child protection plans in Oxfordshire declined between 31 March 2018 and 31 March 2019, from 687 to 592 (95, 14%). The most recent data held by Oxfordshire County Council shows that at the end of December 2019, this number had remained stable and is just below 600.

At the end of March 2019 there were 779 looked after children in Oxfordshire, up from 684 as of 31 March 2018. At the end of December 2019 this had increased slightly to 786 looked after children.

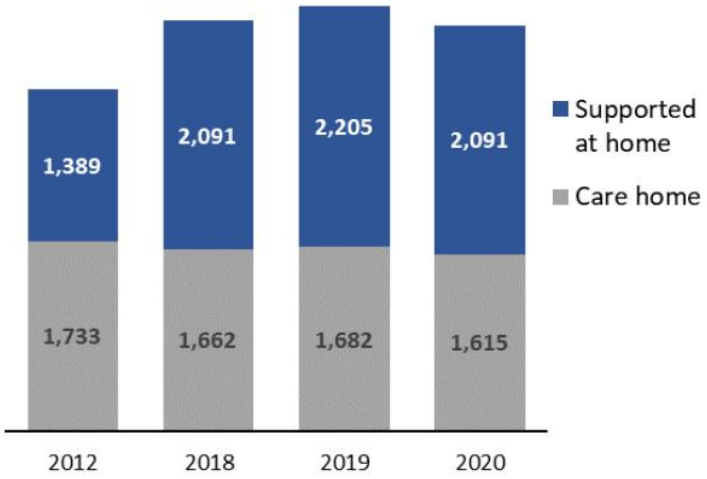
From Jan Dec 2019, there were 1,306 families identified in Oxfordshire that met two or more of the six Troubled Families criteria. This was a rate of 17.2 families per 1,000 families with dependent children in Oxfordshire. The rate was above average in Cherwell (19.9) and in Oxford city (21.7)



Source: Oxfordshire JSNA 2020

Social care

The proportion of older adults receiving a social care service at home (rather than in a care home) has risen. At the beginning of April 2020, 56% of older adult social care clients were receiving a service at home up from 44% at the start of April 2012.



Source: Oxfordshire JSNA 2020

By district, the highest number of older people being supported with long term social care services as of April 2020 was Cherwell and the highest rate (per 1,000 population aged 65+) was Oxford City. Care support is means tested, so if an area has a higher proportion of its older population living in more deprived areas, it is more likely that a higher proportion of the older population will qualify for care. South Oxfordshire had the lowest rates of people supported either in a care home or at home.

C. National and local context

NHS Long term plan

The NHS Long-term Plan highlights three major initiatives to improve community care:

- **A new NHS offer of urgent community response and recovery support:** This is predominantly to improve care for people experiencing a sudden deterioration in their health and involves investing in and enhancing existing community response teams to prevent unnecessary emergency hospital admissions and speed up discharges – with a specific target of people receiving services within two hours in a crisis and within two-days for reablement care. Also, it includes improving access via a single point of access for people requiring urgent care in the community
- **Enhanced care for people living in care homes:** supporting timely access to out of hours support and end of life care, including supporting care homes to have easier and secure access for sharing information about their residents using NHSmail.
- **Enabling people to age well:** this involves identifying older people with moderate frailty at particular risk of deterioration and offering them proactive personalised care and support. Also, delivering a core model for the future care of people with complex needs. This will be delivered through Primary Care Networks (PCNs), where general practices, community teams, social care, hospitals and the voluntary sector work together with the shared aims of enabling older people to stay well, better manage their own conditions and live independently at home for longer.

Delivering these initiatives in an integrated, joined-up way will increase the effectiveness of community services to deliver prevention, crisis intervention, reablement, rehabilitation, end of life care and care for people living in care homes.

Oxfordshire strategies

Over the past year, the implications of the COVID-19 pandemic have resulted in a significant amount of learning and different ways of working within the health system in Oxfordshire. Moving forward it is essential that we learn from the COVID-19 response and continue to integrate community resources that extend the reach of health and social care to support independence. As part of this we are focused on rethinking services to support more planned and preventative care delivery.

Oxfordshire Joint Health and Wellbeing Strategy 2018-23

In line with the NHS long term plan, this strategy sets out the ambitions of:

- Agreeing a coordinated approach to prevention and "healthy placeshaping"
- Improving the resident's journey through the health and social care system (as set out in the Care Quality Commission action plan)
- Agreeing an approach to working with the public so as to re-shape and transform services locality by locality
- Agreeing plans to tackle critical workforce shortages

This is closely linked to the Growth Board health objective outcome to achieve a healthier and happier population and the overall well-being of the population will have improved.

Building on the population life groups identified within the health and wellbeing strategy, this strategy will focus on three life phases, start well, live well and age well. This will help to ensure that the work completed enables us to move towards a population health approach to delivering community services.

Oxfordshire Plan 2050

This plan is a commitment by all 6 authorities in Oxfordshire which builds on the housing and growth deal commitment to development of local plans. Further to the local plans, the Oxfordshire plan will identify key areas for sustainable growth with associated housing / employment numbers, while considering how to help tackle climate change, improve water efficiency and mitigate flood risk. The plan is overseen by a member sub-group (a sub-group of the Oxfordshire growth board), an officer project board and the liaison team. The strategy is now due for adoption May/June 23 following delay due to COVID-19.

The aim of the plan is to develop a framework for future decision making on big issues like development, infrastructure and placemaking. This is an opportunity to plan co-operatively, tackle complex issues that cross our individual boundaries, and draw up a strategic vision to 2050. Key aspirations identified to date include:

- Protect environmental quality
- Strong and healthy communities; enabling independence, encouraging healthy lifestyles, facilitating social interaction and creating inclusive and safe communities and healthy place-shaping
- Support economic growth
- Improve housing availability and affordability
- Improve connectivity and movement

From a healthcare perspective the plan identifies the need to address healthcare inequalities within Oxfordshire. This identifies challenges around ease of access to healthcare provision across the county and the fact that in rural areas this can be difficult for less mobile residents. It also reflects the fact that primary healthcare is under pressure across the whole country, including Oxfordshire, while a growing and ageing population means that access to primary healthcare will be increasingly important.

The plan identifies the approach of healthy place shaping. This refers to ensuring the physical environment, housing and social networks can nurture and encourage health and wellbeing and includes learning from the Healthy New Towns in Bicester and Barton and applying this to other new and existing developments. It identifies the following principles for assessing proposals:

- Work with people to co-produce communities which people value because they have character and a local distinctiveness, which are attractive places to live and work, which promote a sense of identity, and where people feel safe and comfortable.
- Improve health and wellbeing and enable independence, reduce health inequalities and facilitate social interaction where people can meet to create healthy, inclusive and safe communities.
- Enable inclusive social, environmental and economic growth which supports local employment and other meaningful activity.

- Ensure the protection, enhancement and expansion of the natural, built and historic environment.
- Mitigate and adapt to climate change and use a catchment-based approach to water management.
- Provide and ensure access to infrastructure that enables people to be active, which encourages active modes of travel and which does not add to congestion.
- Ensure easy access to infrastructure, facilities and services to enable people to live and age well and which provide early opportunities for people to meet and connect with one another.
- Maintain, enhance and expand easy access to green spaces and nature to deliver multiple benefits for people, place and the environment.
- Minimise energy demand and maximise the use of renewable energy, where viable meeting all demands for heat and power without increasing carbon emissions.
- Provide diversity in the residential offer that improves accessibility, affordability and promotes inter-generational connectivity and lifetime neighbourhoods.

Oxfordshire Primary Care framework

Published in 2017, this framework sets out the Countywide approach to ensuring the sustainability of General Practice. The new model of primary and community care in Oxfordshire will be based on a number of operational principles:

- Delivering appropriate services at scale
- Organised around geographical population-based need
- Delivering care closer to home
- A collaborative, proactive system of care
- Delivered by a multidisciplinary neighbourhood team
- Supported by a modernised infrastructure

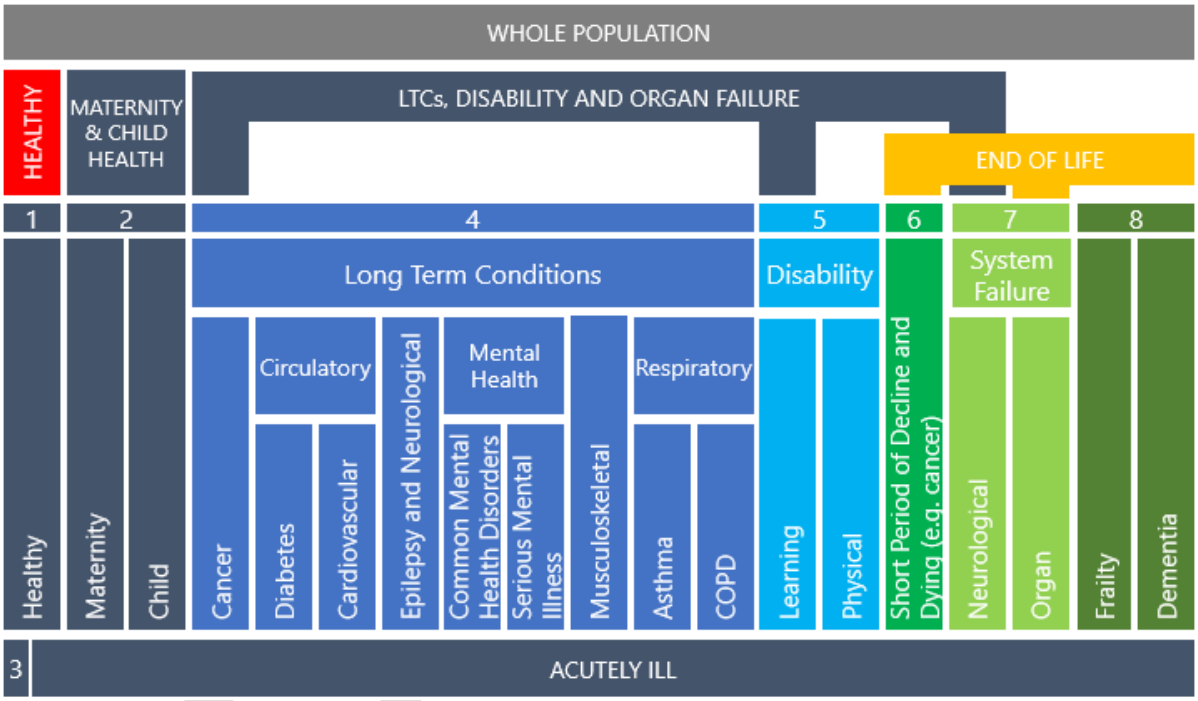
The vision of this framework is:

> To provide a 21st century modernised model of care that works with patients across neighbourhoods and locality populations to provide enhanced primary care, extended primary care teams, and more specialised care closer to home delivered in partnership with community, acute and social care colleagues.

D. A strategy based on population need

We will base our service delivery model proposals on the priorities and approaches set out in the Oxfordshire Health and Wellbeing Strategy and NHS Long-term Plan. This requires pathways and services to be organised at the most appropriate level of scale based on pathways, not siloed services.

Community Services require a flexible way of organising services in a sustainable way that addresses local differences in needs, while ensuring care remains coordinated and suitably resourced. This means enabling local communities to shape services to their particular needs and circumstances, while operating within a county-wide structure that ensures quality and consistency for all Oxfordshire residents. This requires a shift from a traditional specialty/service-based delivery model to a population health approach. For example, a population health model might take the following approach:



Source: Outcomes-Based Healthcare, adapted from the Bridges to Health model – Lynn J, Straube BM, Bell KM, Kambic RT. Using population segmentation to provide better health for all: the 'bridges to health model'. The Milbank Quarterly 2007; 85 (2): 185-208

Learning from national best practice

The strategy will be informed by considering best practice from across the country including:

- Kings fund – Community services, making the most of our assets Reimagining_community_services_report.pdf (kingsfund.org.uk)
- Sussex Foundation Trust - Community services strategy https://www.sussexcommunity.nhs.uk/downloads/news/2019/scft-three-year-strategy.pdf

- Greater Manchester public health network - developing asset based approaches to primary care https://www.innovationunit.org/wp-content/uploads/2017/05/Greater-Manchester-Guide-090516.pdf
- University of Birmingham - Analysis of the profile, characteristics, patient experience and community value of community hospitals: a multimethod study https://www.birmingham.ac.uk/documents/college-social-sciences/social-policy/hsmc/publications/2019/analysis-of-the-profile-characteristics-patient-experience-and-community-value-of-community-hospitals.pdf

Life stages

The Oxfordshire Joint Health and Wellbeing Strategy sets out the following priorities which we will use to shape the strategy for Community services within OHFT:

Start well

The best start in life starts with a baby's mother being healthy before and during pregnancy and childbirth. There is a lasting impact in future years from what happens in the early years of a child's life – influencing future physical and mental health, safety, educational achievement and a successful work life. Schools, the influence of peers and social relationships are formative too. Brain development, attitudes to risk taking and controlling feelings and emotions develop in adolescence and have consequences for health.

Live well

Oxfordshire is above the national average for many health outcomes, but many people still live with avoidable conditions such as heart disease, cancer and diabetes. Risk of contracting these illnesses can be reduced through adopting healthy lifestyles. Early detection of long-term conditions leads to better outcomes.

People who are already diagnosed need to be supported to stay as well as possible and enjoy life. There are some groups of people who are more at risk because of where they live, their age, ethnicity, gender, mental health or other factors. Appropriate targeting of services is needed for them. There needs to be care closer to home and smooth flow between services.

Age well

The number of older people in the county is increasing and is projected to grow further, with the proportion of those aged over 85 increasing by 60-80% in the next 15 years. While people are living longer, many are spending more years at the end of life in poor health.

The number of people with dementia is also growing. The evidence shows that we should identify the people at risk, intervene earlier and deploy multi-disciplinary teams in new ways to support active ageing and prevent loneliness, ill health and disability among older people. There needs to be care closer to home and smooth flow between services.

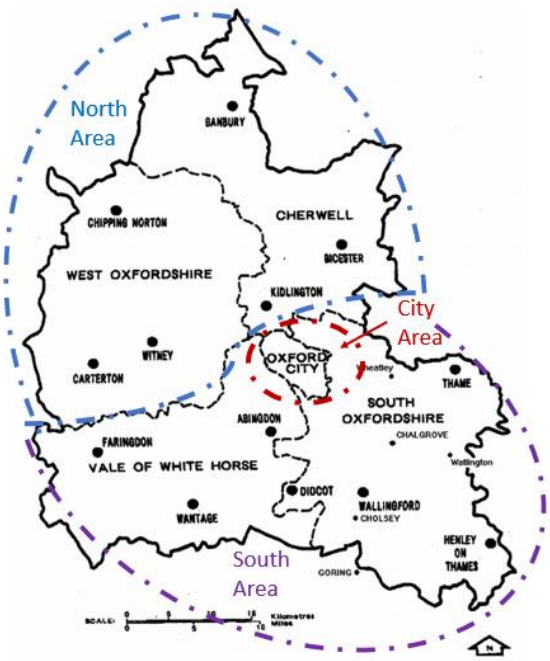
Scales of delivery

Our approach will focus on ensuring service planning and delivery happens at the optimum level of scale. We have identified 4 service delivery scales which will be considered for each service:

Unit of scale	Supports	Best for services that…
Primary Care Networks – Groups of GP practices working with their local community partners	30,000-50,000 people	Support people with relatively common health conditions or multiple needs, who will especially benefit from local access and continuity of care with their GP practice and community 'neighbourhood team'
Districts & Area Networks – Link District Authorities with their Primary Care Networks, community services, residents, commissioners and other local partners	110,000 - 250,000 people	Take a population health focus, share resources and integrate teams across health, social and voluntary sectors; coordinate services that require a suitable scale or multiple providers to sustain quality; help resolve local delivery challenges and develop the workforce. Each Area Network will be supported by a number of local Community Hospitals
Oxfordshire Integrated Care Partnership (ICP)	700,000 people	County-level services that require cross-organisational working, joined-up management and large scale to operate effectively
Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System (BOB ICS)	1.8 million	The BOB ICS covers a population of 1.8 million people, three Clinical Commissioning Groups (CCGs), six NHS Trusts, 14 local authorities and 175 GP surgeries

Area Networks will bring together District Authorities with their local Primary Care Networks, larger scale community health and care services, residents, commissioners and other local partners. Each Area Network will take a population health focus, enabling more effective joint planning and integration of activities across health, social and voluntary sectors.

The services in each Area Network will be provided/supported by a number of Community Hospitals and other local facilities (e.g. practices, community centres, etc.). Area Networks will bring together District Authorities with their local Primary Care Networks, larger scale community health and care services, residents, commissioners and other local partners. Each Area Network will take a **population health focus**, enabling more effective joint planning and integration of activities across health, social and voluntary sectors. The services in each Area Network will be provided/supported by a number of Community Hospitals and other local facilities (e.g. practices, community centres, etc.).


North Area
BANBURY
CHERWELL
CHIPPING NORTON
BICESTER
WEST OXFORDSHIRE
KIDLINGTON
City Area
WITNEY
OXFORD CITY
CARTERTON
THAME
SOUTH OXFORDSHIRE
ABINGDON
CHALGROVE
FARINGDON
Watlington
VALE OF WHITE HORSE
DIDCOT
WALLINGFORD
CHOLSEY
WANTAGE
HENLEY ON THAMES
South Area
GORING

E. Vision & Principles

Our vision is to improve the health, wellbeing, independence and care experiences of individual residents, while strengthening the interdependence of people, families and communities across all of Oxfordshire.

By independence we mean enabling individuals to strengthen and draw on their personal capabilities and resources, their social networks, services and communities to live healthier lives and, to the maximum extent possible, take informed actions to improve their health and care.

Interdependence recognises the importance and value of mutually supportive social connections, reciprocal relationships and the interactions between the determinants of health and wellbeing, in improving the long-term health of people, families and communities.

Based on the strategy and engagement review, we propose the following design principles:

Prevention and early intervention	Maximise the health of the population through a system commitment to 'make every contact count'
Care close to home	Care and support will be provided as close to home as is both clinically effective and most appropriate for the patient, whilst promoting equality of access
Whole person view	Mental health, physical health and wellbeing will be considered as essential and interdependent aspects of the health of a whole person
Continuous improvement	Services will be continuously improved through empowered local teams to improve care while delivering consistent outcomes for patients
Engagement and collaboration	These models will require a high level of engagement and collaboration both across the various levels of the ICS and with neighbouring ICPs
Best practice evidence base	Care will be based on evidence and best practice, will ensure that pathways are aligned, and will avoid unnecessary duplication

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Best practice evidence base

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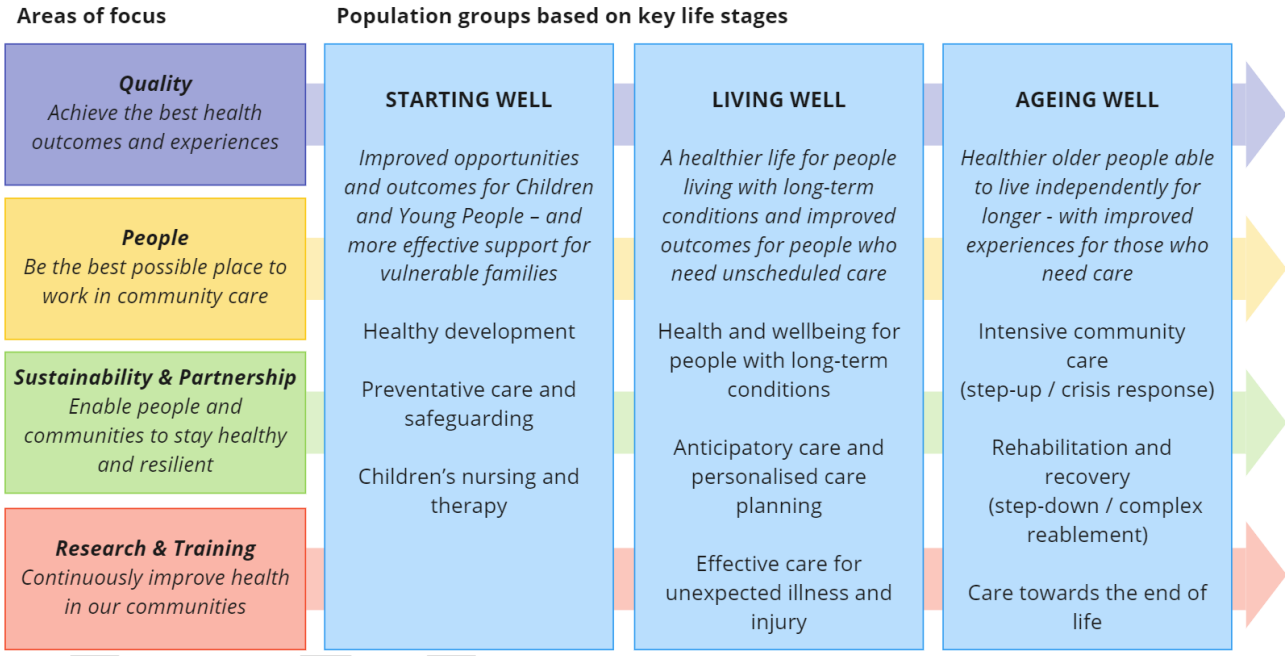
F. Oxfordshire community services improvement framework

The following section sets out the Trust's key areas of focus for community services, to improve the health of the diverse range of people who live, work or study in Oxfordshire. (Please note the term 'health' is used holistically and includes biopsychosocial, spiritual and environmental aspects, incorporating a wide range of factors that contribute to a person's ability to function and their general wellbeing.)

The proposed improvement framework is built around four pillars of particular relevance to improving community health outcomes, which map closely to Oxford Health's Trust strategy and the NHS long-term plan: Quality, Our people, Prevention and sustainability, Continuous improvement (research and training).



Quality – delivering the best possible health outcomes and experiences

Our ambition is to deliver the best possible community care to people in Oxfordshire and improve health outcomes for the whole population. This means we will focus on providing community services that support and enable people to experience longer periods of their lives in good health, by:

- Supporting more children and young people to benefit from a better start in life by extending the range and reach of community support available to them and their families
- Reducing health inequalities by developing services in our communities that better meet the diverse health needs of our changing population
- Enabling older people to enjoy more healthy and independent lives for longer
- Improving health outcomes for people living with long-term health conditions
- Enhancing care for people living with multiple health conditions and frailty and at the end of life

To deliver this ambition, our proposed strategic development plan will prioritise:

1. **Supporting more children and young people to benefit from a better start in life by enhancing the range and reach of community services and support for them and their families**
   - 1.1. Improving access to integrated therapy services for children with physical and developmental needs
   - 1.2. Providing more support to at-risk children, parents and families, when this is needed
   - 1.3. Improving local access to Children's and Young People's mental health services

2. **Reducing health inequalities by developing services in our communities that better meet the health needs of our increasingly diverse and changing population**
   - 2.1. Providing (or supporting the provision of) more specialised care in local primary and community care settings, where this is an effective and sustainable approach
   - 2.2. Focusing on tackling health inequalities for people living in the most deprived areas (e.g. reducing emergency coronary heart disease presentations in Banbury Ruscote and Blackbird Leys)
   - 2.3. Addressing the existing barriers between 'mental health' and 'physical health' services, providing more holistic, joined-up care to some of the most vulnerable people in our communities
   - 2.4. Expanding the capacity and capability of our community health services to respond to housing growth and changes in the demographics of our communities

3. **Enabling more people to enjoy more healthy and independent lives for longer**
   - 3.1. Delivering significantly more evidence-based preventative interventions in the community, to slow the loss of dependence and progression to frailty or ill health
   - 3.2. Minimising the reliance on hospital inpatient care where there are effective and safe alternatives to admission that better maintain long-term independence and wellbeing
   - 3.3. Empowering more people to improve their own health through coaching and self-management approaches, achieving more of the goals they have set themselves
   - 3.4. Implementing new approaches that increase the involvement of patients and service users, carers and third sector colleagues as partners in the delivery of care

4. **Improving health outcomes for people living with long-term health conditions**
   - 4.1. Rolling out clearly defined, evidence-based care pathways for the major long-term conditions managed in the community (including in community hospitals)
   - 4.2. Offering more expert care closer to home and in the community for people with long-term conditions
   - 4.3. Implementing more effective systems for recording, monitoring and improvement of health indicators for people with the most common long-term conditions found in the Oxfordshire population (e.g. hypertension, depression, asthma, diabetes) and those which are found to be above the national average (e.g. cancer, cardiovascular disease, depression, osteoporosis)

5. Enhancing care for people living with multiple health conditions and frailty and at the end of life

5.1. Implementing new service delivery models that deliver more personalised and coordinated community care that prioritises the needs of the whole person, rather than managing each health condition separately

5.2. Reconfiguring care pathways to enable people who benefit from continuity to receive expert generalist care from their local neighbourhood team, while enabling those who require specialist care to receive this in a timely and coordinated way

5.3. Ensuring more patients report that the care they receive meets their expectations of 'good care'

5.4. Enabling more people reaching the end of life to experience the best possible death at home or in a community setting, through improved advance planning and support

Our People – being a great place to work

Our ambition is to ensure our teams and services are attractive, inclusive and supportive working environments where a diverse workforce of caring, highly skilled and motivated people can train, work, lead improvements and develop rewarding careers. This means we will focus on:

- Training and developing our primary and community care workforce
- Creating well-led teams which are empowered to improve the services they provide
- Being a great local employer

To deliver this ambition, our proposed strategic development plan will prioritise:

6. Training and developing the primary and community care workforce

6.1. Enabling our health workers to develop the skills and capabilities they need to meet the population's continuously changing needs, so we can more often deliver the right care at the right time

6.2. Working with range of partners in healthcare and education to develop a thriving delivery network that supports the development and delivery of workforce training and development programmes

6.3. Providing more training and mentoring opportunities in our services that enhance skills, capabilities and performance, at both individual and team levels

6.4. Supporting a greater range of interesting and rewarding careers, with clearer career development pathways and goal-focused opportunities for all our staff

7. Creating well-led teams which are empowered to improve the services they provide

7.1. Developing our most capable staff as local team leaders, with a focus on improving care in their communities

7.2. Enabling high functioning multi-disciplinary teams to work effectively across organisational and geographical barriers

7.3. Configuring our roles, structures and processes to best support effective engagement and collaborative working between clinicians, managers, commissioners, stakeholder representatives and other key partners

8. Being a great local employer

8.1. Attracting and retaining more staff, as evidenced by the Trust's employee surveys and workforce turnover data
8.2. Reducing reliance on agency staff to cover long-term staffing gaps
8.3. Improving workplace health and wellbeing for all our staff
8.4. Developing a more inclusive, diverse and fair workplace culture

Prevention and sustainability – making the best use of our resources

Our ambition is to make the best use of all our resources to sustain our health system and protect the environment, so improving and maintaining the health of our residents and their communities. This means we will focus on:

- Shifting to more sustainable and preventative models of healthcare
- Implementing new operational approaches and infrastructures that enable the delivery of healthcare to become more effective, coordinated and sustainable
- Supporting people and communities to improve their health and resilience
- Enabling our health and care system to become more financially sustainable

To deliver this ambition, our proposed strategic development plan will prioritise:

9. Shifting to more preventative and sustainable models of healthcare

9.1. Shifting from a predominantly reactive, disease-based care model to a more population-based health system where every resident is included by default, allowing greater emphasis on prevention, self-care and effective early intervention
9.2. Testing 'system integrator' and similar coordinating roles that join up care plans, minimise duplicated activity and respond in a more coordinated way to people with multiple health and care needs
9.3. Developing population health needs analysis and corresponding service delivery models at Primary Care Network, District and Area Network levels, enabling locally-tailored plans for community healthcare provision at the optimal level of scale, while ensuring county-wide consistency, transparency and fairness
9.4. Delivering a wider range of modernised health services in and from our community hospitals, enabling them to develop as thriving and sustainable local healthcare facilities where essential services, resources and staff are coordinated and developed to improve the health of local communities

10. Implementing new operational approaches and infrastructure to enable more effective, coordinated and sustainable planning and delivery of community healthcare

10.1. Working with the full range of primary care, secondary care, social care, third sector and commissioner colleagues to streamline and integrate services where this will lead to improvements in health outcomes, patient experience and cost-effectiveness
10.2. Supporting Primary Care Networks to develop as effective primary and community care partnerships, joining-up care pathways, developing and sustaining the workforce, creating attractive, supported career pathways for healthcare workers and making the best possible use of limited resources

10.3. Establishing an efficient Area Network structure linking local community services with their local Primary Care Networks, District Authorities, residents, commissioners and third sector organisations, to support local engagement, coordination and transparency on service planning and to positively influence the determinants of health in that geographical area
10.4. Developing joint clinical and operational structures that function well across multiple health and care partners, delivering more effective multi-disciplinary team and inter-organisational working

11. Supporting people and communities to improve their health and resilience

11.1. Implementing approaches that use a wider range of opportunities to improve health through education, advice and support
11.2. Supporting people to develop and maintain meaningful roles in their families and communities (such as paid work, education, structured volunteering and supported caring responsibilities)
11.3. Developing more ambulatory, outpatient and home outreach services operating in and from community hospitals and other community facilities where this adds value and is clinically and operationally sustainable, increasing local access to professional expertise, shared learning opportunities and specialist facilities
11.4. Developing our community teams and assets to support more local volunteering and health improvement schemes

12. Enabling our health and care system to become more financially sustainable

12.1. Reviewing and, where necessary, reconfiguring our community services to increase efficiency, reduce waste, achieve better value for money and deliver more health improvement outcomes within available resources
12.2. Providing a more robust planning and delivery infrastructure to enable much-needed additional investment to be made into community services, delivering maximum benefit against investment
12.3. Developing more sustainable premises that better support the delivery of effective patient care, reduce the carbon footprint and help to maintain staff wellbeing

Continuous improvement – being a leader in health research and education

Our ambition is to harness the potential of research, education and continuous quality improvement to improve our health services and benefit our communities. This means we will focus on:

- Continuously developing our existing services to better meet the needs of the people they serve
- Using data and technology to gain new insights and improve care
- Testing innovative approaches to address emerging health and care needs
- Developing our research and education activity and capability

To deliver this ambition, our proposed strategic development plan will prioritise:

13. Continuously developing our services to better meet the needs of the people they serve

13.1. Delivering a quality assurance programme to ensure our services meet (and ideally exceed) all applicable CQC and other regulatory standards

13.2. Supporting and encouraging a wider range of staff to train in Quality Improvement (QI) methods and undertake QI projects as a core part of their role

13.3. Embedding QI in the community services culture, by incorporating structured QI activities and expectations in everyday clinical, operational and management work, team learning events and staff appraisals

14. Working with commissioners to update inconsistent clinical pathways and remove perverse incentives and unproductive process measures from service contracts

14.1. Using data and technology to gain new insights and improve care

14.2. Improving access to data that enables services to improve the care they provide, including relevant biomedical data, service data patient feedback and user evaluations

14.3. Developing and applying appropriate metrics and reporting systems to demonstrate the system impact of our services in the high-volume pathways of care, enabling measurable improvements in system performance to be demonstrated over the next 3-5 years

14.4. Delivering upgraded IT infrastructure and systems with increased functionality and more interoperability to better support shared record-keeping, data reporting and analysis, staff workflow and patient access requirements, facilitating the accelerated application of technology-enabled care

15. Developing and testing innovative approaches to address emerging health and care needs

15.1. Developing data-driven models to identify new population needs, monitor the quality of care in our care pathways and identify any gaps

15.2. Developing and testing innovative approaches to improve healthcare and develop sustainable business models

15.3. Applying learning from local pilots to other areas that would benefit and working collaboratively with partners in other areas to share learning, inform benchmarking and contribute to best practice

16. Developing our research and education activity and capability

16.1. Increasing the research capability and capacity of our primary and community care teams, as measured by an increase in the number of staff and participants undertaking research activity in community settings

16.2. Developing more training posts in our services and opportunities for staff to develop educator roles

G. Applying the framework to better meet the population's needs

Children and Young People (Start Well)

Oxfordshire has an increasing and above average percentage of children with social, emotional and mental health needs (around 2.5%).

According to the school census (January 2019) there was a total of 6,464 pupils with learning difficulties in Oxfordshire (including specific, moderate, severe, profound and multiple) in schools in Oxfordshire, including:

- 3,069 pupils with learning difficulties in state primary schools (6% of pupils)
- 2,827 pupils with learning difficulties in state secondary schools (7% of pupils)
- 568 pupils with learning difficulties in special schools (46% of pupils)

According to the JSNA, in January 2019 there were 1,785 pupils in Oxfordshire registered with their primary/main type of need as Autism Spectrum Disorder, 1.9% of all pupils. The proportion of pupils with autism in Oxfordshire's state funded secondary schools was above the England average (2% compared with 1.3%).

The **Health Visiting service** transitioned from NHS to Local Authority in October 2015. Public Health (Oxfordshire County Council) recommissioned the service for Oxfordshire in 2016; new contract started in April 2017.

- There were 7,167 births in 2018-19 to Oxfordshire residents.
- In 2018-19, health visitors had 10,800 direct contacts and 13,589 indirect contacts.
- Pregnant mothers are seen during the antenatal period, and again at 6-8 weeks to receive a maternal mood assessment.
- Prior to COVID-19, babies were seen and checked at least by 14 days old, at 6-8 weeks and at 1 year and 2 years.

The **Family Nurse Partnership (FNP)** supports first time mothers aged up to 19 years. It focuses on supporting young mothers for a healthy pregnancy, improving child's health and development and improving parents' economic self-sufficiency.

Oxfordshire has 200 places available. Once the child reaches 2 years they transition into the Health Visitor Service and receive ongoing advice and support.

The **School Health Nursing (SHN) Service** is for children and young people aged 5-19 years. A new contract continuing to deliver the full service began in April 2019.

During 2018-19 there were 22,066 contacts with SHN and 35,851 interventions. The reasons for interventions mainly fall into the categories identified below:

- Liaison –24% (speaking with others to gather/provide information for a case)
- Mental Health & Wellbeing -18%
- Sexual Health -17%
- Safeguarding -21%

The **College Nurse Service** is for young people aged 14-25 years attending a college. Total contacts in 2018-19 were 1,283 and there were 2,839 interventions. Reasons for interventions were predominantly sexual health (67%). Mental health accounted for a further 10% of interventions.

Over the past 18 months the **Children's Integrated Therapy (CIT) Service** has been reviewed by Oxfordshire Clinical Commissioning Group's (OCCG) in conjunction with Oxford County Council (OCC), with involvement from the Parent Carer Forum, other stakeholders and support from our team as the current provider.

As part of the review, OCCG requested that the service team develop and present a proposed model of best practice which would be efficient, effective and provide the best outcomes for the children of Oxfordshire. The model developed seeks to deliver many of the objectives detailed in the current Oxfordshire Children and Young People's Plan

Since 2011, national legislation requiring a significantly expanded statutory provision of therapy for children with Education Health Care Plans (EHCPs) has hugely impacted on the demand for the service. Data from the Joint Strategic Needs Assessment (JSNA) 2020 shows over the last five years, the number of EHCPs issued per year in Oxfordshire has trebled, from 232 to 706 (+204%). Data from the JSNA also shows a steadily rising number of children with speech, language and communication needs (SLCN) and autistic spectrum disorders. Many of these children require speech and language therapy and occupational therapy.

The new model proposes a tiered approach to therapy provision, a cost-effective and evidence-based approach that has worked well in other therapy services (e.g. IAPT). Therapy will be provided according to individual assessment and offered a Universal, Targeted or Specialist level of service (appendix 2). All contact with the service will be managed by a Single Point of Access. The theme of the importance of multi-agency working to support children's needs is central to delivery.

Older People (Live Well)

As of February 2020, there were 116 care homes in Oxfordshire providing 5,194 care home beds for older people of which 4,020 (77%) included nursing care. As a proportion of the number of residents aged 85 and over, the rate of care home beds for older people in Oxfordshire was 29 per 100, just below the South East (30.4) and England (30) averages. Cherwell and West Oxfordshire were each above the national, regional and county averages.

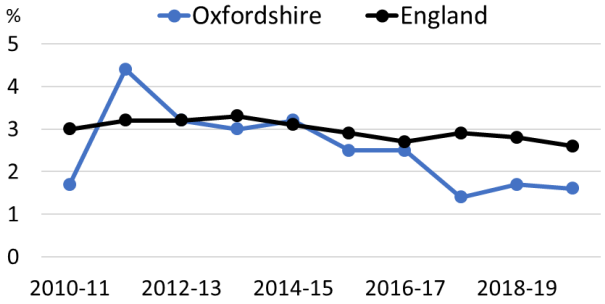
In 2020-21, nearly half of attended appointments with Oxford Health Community Services were for the **District Nursing service**, similar to the proportion in previous years.

Between April 2020- March 21 **Community therapy services** received 7,671 referrals. Of these 16% were emergency, 57% urgent and 27% routine.

Between April 2018 and March 2019, 2,553 people in Oxfordshire received **reablement**. Of these 1,387 were helped to leave hospital, 390 were diverted from hospital and 776 were supported via a community referral.

In the same period 3,140 people who made requests for support in Oxfordshire received equipment or Occupational Therapy (OT) support. This is equivalent to a rate of 579 per 100,000 population, above the average for Oxfordshire's nearest neighbours (451) and below the England rate (770*).

When older people are admitted to hospital, Oxfordshire currently has a below national average rate of reablement. As of 2019-20, Oxfordshire was ranked 13th in its group of 16 statistical neighbours on the % of older people offered reablement services following discharge from hospital.



People at the end of life (Age Well)

In people of all ages in Oxfordshire, deaths in usual place of residence have increased from 1,808 (37% of the total) in 2004 to 2,724 (51%) in 2018. In older people (85+ years), deaths in usual place of residence have doubled from 756 (45%) in 2004 to 1,544 (62%) in 2018. There is little difference between the districts in Oxfordshire.

To meet the needs of our ageing population, we will work with all key partners to maximise independence through collective action for Living Longer, Living Better and will roll-out an updated model of care, with particular focus on developing four key community-based care pathways designed for older people and those with frailty:

- **Anticipatory & preventative;** Proactive care for people with long-term conditions and frailty coordinated by locally integrated MDTs; plans to improve health and independence will be supported and actively monitored by PCNs and neighbourhood teams, working collaboratively.
- **Urgent Community Response;** Developing existing community and primary care visiting services into a more accessible and effective 24/7 response within 2 hours of contact, that provides the right response from the right professional at the right time.
- **Intensive Community Care;** Expanding our existing ambulatory care services into a more robust, safe and effective alternative to acute hospital admission, tailored for the needs of older and frailer people, operating 365 days a year.
- **Community Rehabilitation;** Streamlined in- and outpatient care delivered in / supported by Community Hospital Hubs, 7 days a week including: Intensive rehabilitation pathway, Bariatric / Plus-sized care pathway, Stroke rehabilitation pathway, Sub-acute frailty care pathway.

Within the anticipatory care theme, a significant amount of work is currently ongoing in this area around the **'Ageing well – 2hr community response**' project. This is a national NHS initiative which Berkshire, Buckinghamshire and Oxfordshire ICS are delivering as an accelerated test area. The project focuses on two key elements:

- Development of a hub and spoke model within Thames Valley Integrated Urgent Care with 111 acting as a single point of access with place-based hubs mobilising the locality urgent community response
- Working across health and social care partners to develop a new offer for intermediate care delivering the national asks of a 2-hour urgent community response and 2-day access into intermediate care services. This will be delivered through integrated place-based services: acute care discharge and ambulatory teams, primary care networks, social care and voluntary and community services to provide longer-term and anticipatory care

H. Implementation approach

Engagement and communication

Understanding and reflecting the views of stakeholders in this strategy will be a central part of delivery. Our approach to engagement for this strategy will be based on the following principles:

- Listening to the views and experiences of local communities to inform future decision making both in regard to specific proposals and across the County more widely
- Ensuring staff understand the objectives of the strategy and have an opportunity to share their feedback to inform future plans
- Providing clear and consistent messages and information to all stakeholders
- Continually reviewing and developing this engagement plan to ensure it takes into account the views of all stakeholders
- Promoting any services delivered during pilots to relevant stakeholders to increase referrals and enable effective evaluation of impact

To ensure that this strategy builds on what we already know it will be informed by historic engagement relating to community services including: reducing delays; the OX12 project and the Big Conversation and Consultation. Based on this we will draw out key themes and insights to support strategy development.

In addition, we anticipate completing the following engagement as part of the development and implementation of the strategy:

Communities and patient groups;

- Focus groups/meetings. Either face to face, if allowed, or virtual small group engagement.

Patients and families;

- Interview patients and carers/family/visitors
- Group discussion toolkit – while COVID-19 restrictions in place for meetings.

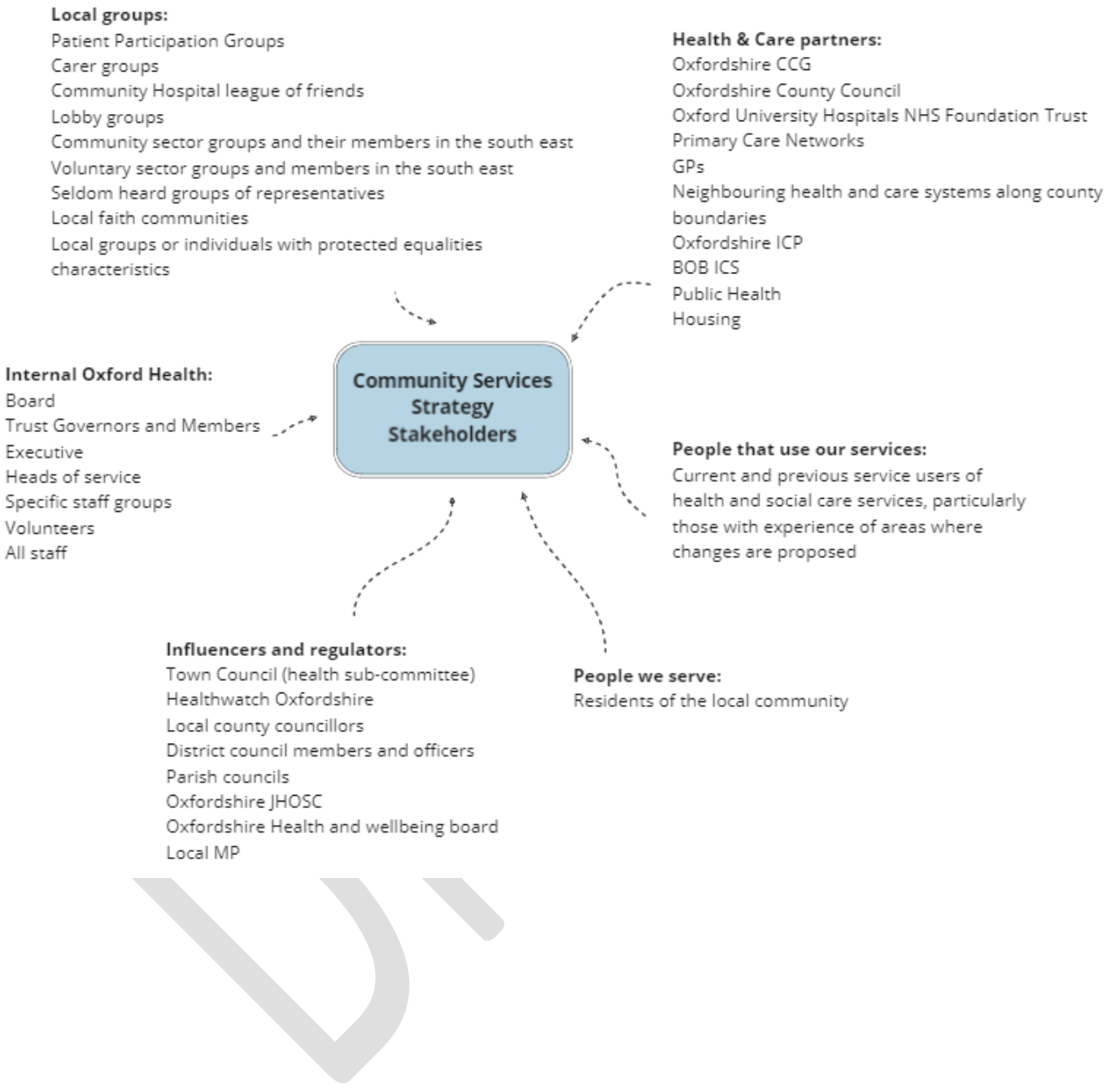
Staff;

- Team meetings and dedicated engagement sessions will be used to explore staff feedback and shape proposals.

General public;

- Surveys will be used to gather feedback. Healthwatch and local community groups will be asked to help to publicise.
- Local print and broadcast media and social media will be used to raise awareness.
- OCCG and OH public websites. Dedicated space will be made available to host documents and information about the project.

To date the following stakeholder groups have been identified:



Engagement will follow the NHS 10 principles of participation:

1. Reach out to people rather than expecting them to come to you and ask them how they want to be involved, avoiding assumptions.
2. Promote equality and diversity and encourage and respect different beliefs and opinions.
3. Proactively seek participation from people who experience health inequalities and poor health outcomes.
4. Value people's lived experience and use all the strengths and talents that people bring to the table, working towards shared goals and aiming for constructive and productive conversations.
5. Provide clear and easy to understand information and seek to facilitate involvement by all, recognising that everyone has different needs. This includes working with advocacy services and other partners where necessary.
6. Take time to plan and budget for participation and start involving people as early as possible.
7. Be open, honest and transparent in the way you work; tell people about the evidence base for decisions and be clear about resource limitations and other relevant constraints. Where information has to be kept confidential, explain why.
8. Invest in partnerships, have an ongoing dialogue and avoid tokenism; provide information, support, training and the right kind of leadership so everyone can work, learn and improve together.
9. Review experience (positive and negative) and learn from it to continuously improve how people are involved.
10. Recognise, record and celebrate people's contributions and give feedback on the results of involvement; show people how they are valued.

Where formal consultation is required to assess a change proposal, we will follow the NHS consultation process. A summary of the approach can be found here: https://www.england.nhs.uk/wp-content/uploads/2017/05/patient-and-public-participation-guidance.pdf

Supporting plans

As part of developing the strategy implementation plans, OHFT will also put in place refreshed plans for:

- Size and configuration of future estate
- Shared and inter-connected IT systems
- Skills, configuration and requirements for our future workforce models
- Ongoing organisational development and culture change
- Research strategy for Community Services

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We welcome feedback from a wide range of stakeholders. If you would like to send us any comments or suggestions, please contact us at:
communityservicesfeedback@oxfordhealth.nhs.uk