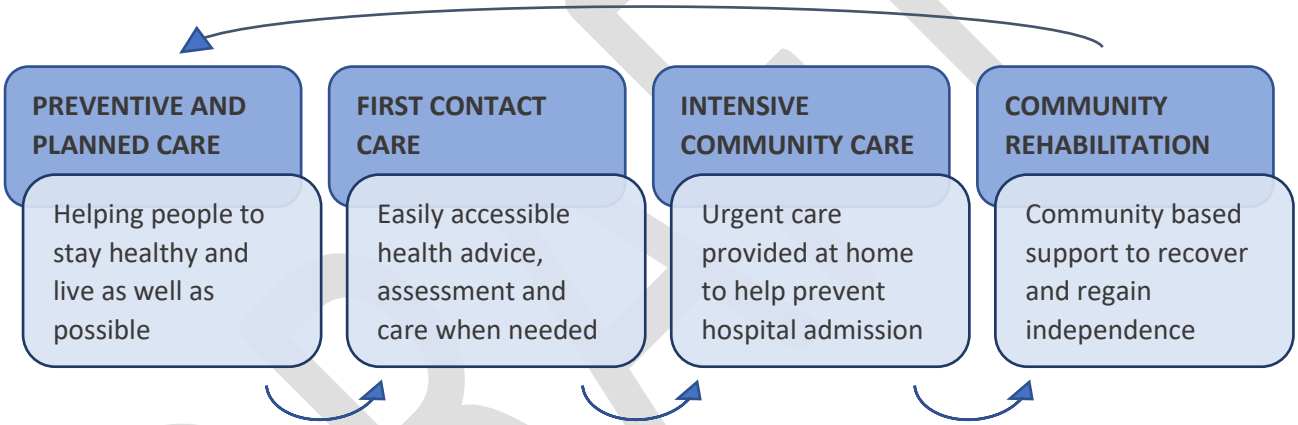
COMMUNITY SERVICES PATHWAYS REVIEW

Our vision for community services in Oxfordshire

People experience a continuum in terms of the support and care they need and that this varies over time. Some individuals live with complex health and care needs that persist throughout their lives. Others may have complex needs that following intervention allow them to live independently with support from their GP and community team. Some people will have episodes of ill health requiring intensive periods of support, followed by a period of supported recovery and reablement. Others will need a different range of support near the end of life.

Due to these changing needs, the type of community services people require changes over time. These community services have been grouped together into four pathway areas, to identify the opportunities to better join-up care and clarify the key benefits that the services in that pathway should provide – the overarching aim being to enable more people to live healthier and more fulfilling lives, maximising health, reducing illness and improving wellbeing.

Four priority areas within community services have been identified:



What changes are required to deliver our vision for Oxfordshire and meet people's needs?

Based on the gap analysis, data compendium and public feedback, a number of service developments have been identified to strengthen the community care pathways, improve quality of care and enhance service user experience.

Preventive and planned care

A central principle of the community services strategy is to enable people to enjoy independent and healthy lives for as long as possible. The preventive and planned care services with community services enable people to remain independent and live as well as possible with any long-term health or care needs. Bringing together both primary (such as GPs) and secondary (services provided within the community and hospital) is central to this. These services also include improved health for people living in care homes and planned care in the last year of life.

Areas of development identified to improve preventive and planned care include:

The Oxfordshire Way	Oxfordshire County Council are leading a piece of work to develop improved understanding of the community assets within Oxfordshire and identify opportunities to support communities to enable people to remain independent. Working with the voluntary and community sector and wider partners, this piece of work aims to deliver a strengths-based assessment of how social capital, community capacity and connections can be supported to increase

	independence. Bringing together stakeholders from a range of organisations including local authorities (county, city and districts), public health, voluntary and community sector, healthcare partners. This work is broken into two areas of work. The first, a Joint Strategic Strengths assessment is a broad exploratory diagnostic, to understand what is already working well, what could be better and explore best next steps to develop alternatives to dependence on traditional social care support. An initial report is due in March to identify opportunities to strengthen community capital. This work is being led by community catalysts, a national leading organisation on local area development, shared lives, developing community capital, links to social prescribing. The second part of this work looks at anticipatory care prevention. Linking with PCNs, the focus is on securing funding to expand existing community organisations. Initially this has including securing funding to extend work supported through the Covid improvement fund past March 22. This area of work has close links to social prescribing (see below) with a focus on enabling people to have a role in shaping their own care and moving people away from social care dependence. It is also aiming to build an evidence base to support the reasons why this work is being done.
Social prescribing	The Oxfordshire Clinical commissioning group is leading a collaborative piece of work to develop a strategy for social prescribing. This sets out the vision and recommendations relating to strengthening social prescribing and making it sustainable. It identifies relevant information broken down into national, regional and Oxfordshire priorities. The strategy is framed around NHS England common outcomes framework which identifies three groups; • Person being referred; Looks at whether health and wellbeing is improved, more in control, improved connectedness, better managing issues • VCS groups; Supporting engagement and funding as well as measuring impact • Wider health and care system; opportunities for social prescribing to deliver reduced bed stay, A&E attendance and staff morale around social needs The strategy is due to be completed in March 2022.
Neighbourhood teams	Working closely with our developing Primary Care Networks, we will bring together and modernise a number of community health services that currently operate separately into more integrated Neighbourhood Teams; these Neighbourhood Teams will consist of locally-based multi-professional and multi-agency community health and care professionals, including GPs and Primary Care Nurses, District Nurses, Specialist Community Nurses and Therapists, Care workers, Social Prescribers, voluntary workers, secondary care experts and other professionals. Working closely with their local GP practice teams, the Neighbourhood Team will take responsibility for leading, planning and delivering care in their local community for older people and frail people with complex long-term conditions,

	multi-morbidity and frailty within a defined population or geography (e.g. the residents of one or more PCNs). Strengthening Neighbourhood Teams will improve planning and delivery of care for older or frail patients with more complex long-term conditions, multi-morbidity and frailty within a defined population or geography (e.g. the residents of one or more PCNs).
Community hubs and network areas	Development of three Community Network Areas is proposed; North, Central and South Areas. They will support a population of around 250,000 people and coordinate community assets. Their focus will be on population health improvement, preventing ill-health and optimising the independence and wellbeing of residents, while reducing health inequalities. As part of this work, it is also proposed to progress the development of multipurpose community 'hubs' to support a range of health and care services, based at an accessible community site (e.g. community hospital, health centre, day centre). These will include visiting services, clinics, outpatients, voluntary and community group activities and more. They will be run with locally empowered leadership – engagement with the community is key. They will support new services in response to changing needs, bringing together local health and care services, voluntary and community groups, Primary Care Networks, Community Hubs, secondary care and Local Authority teams.
Community end of life care	Development of services based within the community to care for those nearing the end of life at home wherever possible and desired by the patient. Collaborative care will be provided by community-based teams including District Nurses, Hospital@Home, hospice specialist teams and the wider voluntary and community sector organisations.

First contact care

When an individual needs additional care it is important that they can easily access health advice and assessment when needed. This group of services includes care for minor injuries and common illnesses that require treatment. In addition, when people are in crisis community services provide emergency and urgent care response 24 hours a day, 7 days a week.

The NHS Long-term Plan aims to create a more effective system of urgent and preventative care, where suitably resourced and integrated teams are empowered and enabled to meet the common healthcare needs of the population; 24 hours a day, 365 days a year.

The intention is for the default place for most urgent care and end-of-life care to be the person's home or an appropriate community healthcare setting, whenever that patient does not require the resources of an acute hospital or specialist facility.

Areas of development identified to improve first contact care include:

County-wide Single Point of Access (SPA) & Care Coordination Hub	An Oxfordshire Single Point of Access (SPA) will be developed as a coordinated access point where a range of professionals and services share a single point of contact. It will operate 24 hours a day, 365 days a year. Information and requests for support across the range of health and care need will be received through a joined-up, coordinated triage system.

	Having one common access point where people can access all the key community services in Oxfordshire will greatly assist services to work collaboratively to provide the best care possible for patients in or near their home. We will create both a physical and a virtual space for professional teams to connect more effectively and work in proximity to each other, improving multi-disciplinary working and ensuring the right people are caring for each patient at the right time. This will add more value to care, with less wasted effort due to improved coordination between services. Patients with urgent care needs or health conditions will be rapidly assessed, diagnosed and treated at home or in a suitable community setting, supported by appropriate diagnostics, without needing to be admitted to hospital. This process will identify the person's needs, provide initial clinical advice or care support and arrange urgent (2-hour) and non-urgent responses as required As an important adjunct to the SPA triage process, the Care Coordination Hub tracks the outcome of the initial response, coordinates the deployment of the community-based teams and services and oversees the initial management of the patient, escalating or de-escalating care as required. The Coordination Hub team enables the patient to receive the right care, at the right time, by the right professionals – and ensures the response is safe and effective.
Minor Injuries Services, UCCs and 24/7 urgent GP services	Patients with urgent care needs or health conditions will be rapidly assessed, diagnosed and treated at home or in a suitable community setting, supported by appropriate diagnostics, without needing to be admitted to hospital. Within Oxfordshire an Urgent care centre pilot is currently being completed at the Fiennes centre to test how this type of care might be delivered and how it can improve patient experience. This pilot is due to be reviewed in May. Currently the centre operates mon-fri 8-6 but longer term the ambition would be to develop it to a 24/7 service. This service is available to all ages for walk in or GP/111 referred appointments. The centre does not have x-rays or diagnostic on site.

Intensive community care

For patients with a higher level of need community services can provide stepped-up care that is needed on a same day/ urgent basis. This can be provided for a number of reasons including to prevent a deterioration, care at home as an alternative to a hospital admission or effective 24/7 palliative care in the last weeks of life.

Areas of development identified to improve intensive community care include:

Ageing Well: Urgent Community Response (7-day Integrated Care at Home)	Oxfordshire has a vision to transform community health services to provide more responsive and flexible services, providing support to those that need it the most. As part of the 2-hour response, flexible teams will work across primary, community and social care providing recovery, reablement and rehabilitation support to individuals keeping them well, preventing crisis and supporting recovery.

	The Urgent Community Response team is dispatched by the Single Point of Access team. It provides a rapid 2-hour response to residents at home, drawing on a range of healthcare professionals. It operates seven days a week from 8am to 8pm. It typically responds to frail people who have had a deterioration in their health or another incident, such as a fall, and require an urgent (non-emergency) assessment. The team also provide prompt and effective palliative care in the last weeks of life. The team assess and treat patients at their own home or in care homes to avoid a hospital admission or readmission. They will refer on to other urgent care services or reablement services if required. Integration of the primary care visiting service, OOH GP services and urgent DN responses into an integrated 7-day response is also proposed. By October 2021 response to urgent problems will be delivered within two hours. This service will be available seven days a week, from 8am- 8pm. Community services will receive enhanced medical support and capacity so that more complex treatments can be undertaken out of hospital settings. This will include early and holistic assessments of complex elderly patients at risk of admission. This will be in the form of direct patient assessments as home visits or at community hubs/hospitals, MDTs and direct support and supervision of admission avoidance/urgent community response teams.
Community Same Day Emergency Care (SDEC) Units: Ambulatory Care	Ambulatory Care units provide same day care to patients who have an acute illness. The patient is seen in a special facility where they can be assessed, diagnosed, treated and go home the same day, without being admitted into hospital overnight. Strengthening this service is of particular benefit to older people with frailty. There are currently Ambulatory Care units in Abingdon CH, Witney CH, Townlands CH (Henley), the Horton (Banbury) and the John Radcliffe (Oxford) hospitals.
Community Same Day Emergency Care (SDEC) Units: Hospital at Home	The hospital at home team provides intensive care and treatment at home for people with acute illness or health conditions that would otherwise require a stay in a hospital bed – also known as ‘stepped up’ or ‘subacute’ care. The service will operate as a multidisciplinary team, working closely with Ambulatory Care teams, the Urgent Community Response and other care services to provide a coordinated package of care that can avoid the need for an unnecessary hospital admission, where this is the best option for the patient.
Complex End of Life Care	Care for those nearing the end of life for whom a period of in-patient care would be preferable to care at home (e.g. carer burnout and fatigue; patient lives alone without support between carer visits; there may be symptoms which could be more easily stabilised in an in-patient environment). End of life patients will be supported by an expert End-of-Life-Care team, working closely with neighbourhood team. Ambition is to get people home when nearing the end of life wherever possible. However, specialist beds are also provided for people nearing the end of life. Not all patients admitted to one of the specialist palliative care beds will come in to die there, and some will have a planned return home. Two beds have so far been opened within Wallingford community hospital alongside hospice provision within the wider county.

Community rehabilitation

After a period when patients need more acute care, community services are also able to provide a reablement and recovery of function to enable patients to regain their independence. This includes both specialist and generalist rehabilitation. Community bed-based nursing and therapy are provided within community hospital and community hub (nursing home) beds. In addition, care is provided by social care services to care for those who need support at home to regain their independence.

Areas of development identified to improve community rehabilitation include:

Ageing Well: 2-Day Community Response (Short-term Home Reablement)	2-Day UCR Team will provide tailored packages of intermediate care, or short-term reablement, for people in their own homes. They aim to restore independence and confidence, to avoid an admission or readmission. The service will operate seven days a week and provides care package in accordance with two-day national standard. By April 2022 access will be provided within two days to temporary care to help people get back their independence. This service will be available seven days a week, from 8am- 8pm.
Live Well at Home (Home Care & Post-Discharge Reablement)	Coordinated by a MDT, The Home Reablement services carry out an assessment in the resident's home and help them to regain as much independence as possible, to enable them to live at home safely. This support might include help with managing meals, medication, washing, dressing, personal hygiene, getting up or going to bed.
Community reablement beds	Short-stay beds provide focused reablement for a short period of time to patients who are unable to return home safely but do not require the more intensive treatment provided in a Community Hospital inpatient unit, while awaiting next stage of their care. This option provides better, more social environment than a hospital inpatient setting for patients to recover, also frees up capacity in hospital.
Community Hospital inpatient pathways (nursing and therapy)	Community Hospitals provide services and facilities that support the rehabilitation and recovery of patients who no longer require acute hospital care, allowing them to resume independent living more quickly. This includes a relatively small but important and potentially vulnerable cohort of patients who require a period of expert nursing or therapy in an inpatient setting, such as stroke recovery, intensive therapy or nursing needs, subacute medical care and bariatric or end of life care. Over the past decade, a growing body of clinical evidence from the UK and around the world has demonstrated that admitting someone for general bed-based hospital care is not the best option in many situations, particularly for frail older people. This is because: • Hospital stays increase the risk of acquired infection or injuries from falls • Patients in hospital are frequently less mobile leading to deconditioning of muscles and loss of function, particularly for older people placed into 'general' inpatient settings without focused interventions • Extended hospital stays can affect people's confidence and ability to live independently for a long period of time • Admission to hospital can be confusing or distressing for many people, especially for those with mental health problems or dementia

A working group of clinical and professional experts from across the system has been reviewing the clinical model for community bed-based care to identify an improved care model. This work has defined the inpatient care interventions and staffing expertise required to meet the needs of key cohorts of patients within the Oxfordshire population, in order to deliver better health outcomes:

- Community rehabilitation - A bed-based assessment and rehabilitation offer usually for those with frailty. The type of rehabilitation and recovery varies between locations based on the complexity of the patient need
- Community reablement - People who require a short period of focused bed-based reablement or assessment before transfer to Pathway 1 (home reablement) or Pathway 0 (no further reablement required) or who may need a permanent placement in long term care (pathway 3)
- Sub-acute medical care and stabilisation - Those who are not medically optimised with frailty, multimorbidity or complex needs experiencing a health crisis who require an actively managed period of stepped-up monitoring, medical treatment, nursing care or therapy until they are stabilised but don't need the facilities of an acute hospital
- Bariatric rehabilitation - People with high BMI requiring specialised equipment, facilities and professional input to enable them to experience safe care, in order to be able to live well at home and access appropriate weight management support
- Stroke rehabilitation - People who have had a stroke and who require a period of targeted rehabilitation in an environment with specialised staff and facilities
- Specialist care towards the end of life – The majority of people express a preference to die at home when nearing the end of life. However, specialist beds are also provided for people nearing the end of life. Not all patients admitted to one of the specialist palliative care beds will come in to die there, and some will have a planned return home
- Confusion - Those with acute confusional state (delirium) and/or dementia who are sub-acutely unwell require clear goals to optimise their recovery and prevent delays in inappropriate care settings. This needs to align with community-based services caring for these patients.
- Neuro-rehabilitation - Inpatient provision for those with who need level 2 rehabilitation alongside the existing stroke pathway

The inpatient unit at Wantage Community Hospital was subject to temporarily closure in June 2016, following the identification of a legionella risk that required building works to address. Since this time, the general beds that this unit provides have not re-opened and residents requiring bed-based care have received this in their own home or in community beds in other Oxfordshire hospitals. Oxfordshire CCG and Oxford Health NHS Foundation Trust recognise the value of the hospital to local residents and have committed to ensuring it has a thriving future. Considering the future of the hospital's inpatient unit as part of this county-wide clinical review and public engagement work will enable a long-term decision to be taken on how the services at the hospital can best be developed to benefit the local population, including the future of the inpatient beds.

Anchoring service improvement planning and engagement in communities

Across the county, a number of geographical reference points anchor an improved health and care system within local communities. Having these fixed points will be necessary to involve the public in the development of plans that are locally supported, clinically evidence-based, operationally feasible and affordable to deliver. Four service delivery scales have been identified 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 – These 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

As well as directly providing services as healthcare sites, these points will be used to build and support key services operating in the homes and communities located around them. They will act as 'hubs' to shape future service provision equitably and consistently, while also tailoring provision to local needs and circumstances. While many existing services will not change location, their future planning will be undertaken by reference to these fixed points through the service review process and engaging with patients and the public. 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.