Oxfordshire 'ACE' Partnership Programme

"The right care for Mrs Oxfordshire in the 21st Century"

Report to Health and Overview Scrutiny Committee 10th Nov 2011

The ACE – Appropriate Care for Everyone – Programme

Introduction

1. The two current public sector commissioning organisations, NHS Oxfordshire and Buckinghamshire Cluster (OBC) and Oxfordshire County Council (OCC) have come together with the three main health providers, Nuffield Orthopaedic Centre (NOC), Oxford Radcliffe Hospital Trust (ORH) and Oxford Health Foundation Trust (OH), alongside the Oxfordshire Clinical Commissioning Group (OCCG) to form a new partnership.

2. This commitment came out of a meeting of the lead clinicians and managers in each of these organisations on July 7, 2011. This meeting brought together for the first time the new OCCG with the five other organisations to analyse from each other's perspective the issue of delayed transfers of care (DTOC).

3. All the national literature and local reports agreed that delayed transfers of care (DTOC) can only be reduced by doing 3 things:

   - Adjusting present capacity levels in acute and post-acute care
   - Adjusting the discharge process
   - Avoiding the initial admission

4. Within the recommendations of these reports, there were 3 key themes that came out as means to reducing DTOC rates.

   - The need for the right information to the right people – both in the form of information for patients and front line staff about the whole process, as well as robust and relevant data for management from which they can base strategic decisions.
   - The importance of Whole System Working at all levels (not just Whole system working between senior players).
   - Key service changes within the discharge process within acute and community hospital care.

Aims

5. All the organisations across Oxfordshire working together delivering and commissioning health and social care, so that every adult can say they are receiving care that is acceptable and appropriate to their needs in the 21st century. Delivered by a systematic, step change approach, signed up to by all partners, that delivers a 'no delay' resilient and responsive integrated health and social care community system.

- To deliver a viable community provision to avoid admissions and to deliver a comprehensive Early Supported discharge service across the county, for the 18+ population.

- To reduce the over dependence on acute care and bed based long term care in Oxfordshire, due to a lack of viable alternative capacity which has led to Oxfordshire becoming stuck in a cycle of risk adverse practice, relying on difficult to access, fragmented provision in the community.

- To utilise the new commissioning levers (e.g. changes in tariffs and new national investment), to allow the development and up-skilling of community staff in a step change approach whilst down-sizing the acute provision.

- To make the substantive change, there is a requirement for a fundamental change in culture and practice and in the way providers work with each other, especially across the integrated clinical pathway approach.

- Ensuring the joint health and social care approach is delivered and sustainable.

Summary of the ACE Programme - the Five Workstreams

6. Model of Care

The clinical delivery areas it covers are:

- Admission Avoidance (Help keeping me out of hospital)
  Hospital at Home
  Crisis Home Support Service
  Care Home Support Service
  Single Point of Contact and the new 111 service
  Rapid Intervention Service for End of Life Care
  Community End of Life Care Matrons
  GP Triage of Ambulance Cases
  Frequent attenders

- Integrated Community Teams (I know where to go to get the help I need)
  Physical and mental health community teams
  Adult Social Care Locality Teams

- Short Term Community Bed Based Care (When I can't be treated or cared for at home, I go to the right place).
  This is mostly focussed on more effective use of the current 300 beds in community hospitals and intermediate care.

- Maintaining Independence / Long Term Care (I get all the help I need with everyday living)
  Personal Health Budgets and Social Care Budgets
  Respite Care
  Long Term Conditions
  Support at Home
  Self Care
  Re-ablement

- Acute Services (If I need to go to hospital, I get the right care while I'm there and only stay as long as I need to.)
  Early Supported Discharge
  Elective Pathway
  Pathways into hospital
  Pathways during stay in hospital
  Urgent Care Pathways
  Acute / Community Interface: Whole System Pilots North and South
  ORH Discharge Planning

- This will be supported by Workforce Development and culture change

7. Re-alignment of community bed based care

In 2010, the criteria for bed based care in community hospitals was taken away, and since then individuals with no further rehabilitation potential have been transferred into community hospitals. This means that at any one time up to 30% of the community health bed stock can be filled with individuals waiting for placement in a care home, and not requiring medical treatment or rehabilitation. Therefore work is underway to develop inclusion criteria for community health beds and community short stay social care beds, to ensure individuals are transferred from acute care into the right place for their needs; this will also reflect the resources these two types of beds are set up for. It is anticipated that the flow through the community health beds will be improved, with more people being able to access these beds each month.

8. Agreement on the transfer of the £6.1m funding from health to social care

Agreement on the areas in which the new money to social care should be utilised was agreed in August, and is already showing results. There is now no individual waiting for funding for support at home, the wait now is for capacity in some areas of the county.

9. New social care emergency/crisis home support service

   The proposal for an emergency/crisis home support service was agreed at September's Older Persons Joint Management Group. With fast track procurement, it is anticipated that this will be up and running in December 2011.

10. Finance and Governance

The aim of this work stream is to review, re-align and develop the section 75 pooled budgets that support the delivery of care and support for older people and people with physical disabilities and to ensure the governance of finance and decision making is robust and is led by the Health and Well Being Board.

It has been agreed to develop two commissioning strategies one for older people and one for people with physical disabilities/long term conditions. It is also intended to separate the older people and physical disability elements of the current pool for April 2012 and to review the addition of all Acquired Brain Injury money and some of the neurological money into a physical disability pool. It will also be looking to identify other funding and services that could and should be part of the pooled budget arrangements

11. Communication

The aims of this work stream are to

- have a single voice across all the organisations to the public on our commitment to develop the care and services required to abolish avoidable delays
- To have taken the learning that patients and the public have given us over the last four years, and put it into the ACE work
- To have engaged with the people of Oxfordshire to ensure that we have their endorsement of any new plans
- To have engaged with all our stakeholders, so that they have been informed and contributed to the ACE programme
- To have an open and transparent communication delivery by keeping a proactive approach by a live web page and regular briefings / newsletters to all stakeholders including the press

12. Metrics and Evaluation

The aim of this work stream is to achieve an alignment of informatics information across Oxford Radcliffe Hospital Trust, Oxford Health Foundation Trust,

Oxfordshire County Council and NHS Oxfordshire and Buckinghamshire Cluster, to reflect the real position on patient flows across Oxfordshire. It will also agree the data set to be used and to have a real time reporting mechanism that demonstrates the time between each step of a patient's journey.

This will mean the whole system has accurate real time information on which to base decisions on and the whole system changes can be monitored over time.

There will also be an external evaluation of the changes and improvements across the whole system in Oxfordshire.

13. Contracts and Tariff Changes

The aim of this work stream is to investigate and collate the information on proposed tariff changes in April 2012, to inform the ACE Programme Board of implications so that they can agree the appropriate arrangements to maintain good quality services and patient flows

Alan Sinclair

Lead Commissioner Social Care for Adults

Fenella Trevillion

Head of Partnerships – PCT

1st November 2011

Appendix One

ACE Programme Governance

Terms of reference of Programme Board – September 2011

Core members

- Alan Webb – NHS Oxfordshire
- David Bradley – Oxford Health Foundation Trust
- Paul Brennan – Oxford Radcliffe Hospital Trust
- John Dixon – Oxfordshire County Council
- Stephen Richards – Oxford Clinical Commissioning Group

Associated clinical members

- Dr James Price – Clinical Director. Medical and Ambulatory Directorate ORHT
- Dr Joe McManners – GP, Consortium Locality Lead
- Pete McGrane – Interim Clinical Director Oxford Health Foundation Trust

Supporting officers

- Alan Sinclair – Adult Social care
- Fenella Trevillion – NHS Oxfordshire
- Programme Lead – NHS Oxfordshire
- Sarah Adair – Head of Communication NHS Oxfordshire

Programme Board responsibilities for the re-design

- Describe, agree and communicate widely the long term vision
- Be the champions of the change programme
- Develop other people's capacity to be change champions
- To hold to account those delivering the granular plan to deliver the long term vision
- Ensuring continuous communication with all those who can assist in making the changes happen
- Drive the decision making at local operational levels to deliver the change and delegate the responsibility to make it happen
- Drive the use of IT to provide critical information and aid decision making both at the strategic level and at the team delivery level
- Be mindful of reaction of the majority of staff to change causing insecurity, and agree strategies to reduce the impact as far as possible
- Will be the sign off Board for the graduated change programme

Current day to day leadership

Will be the responsible cross organisational board for the monitoring on a day to day basis of the system delays – DTOC position and live interventions or changes that need to be agreed and acted on

Meetings

To be held monthly, in the week before the Joint Management Group for the Older Peoples and Adults with Physical Disability Section 75 Pooled Budget

When a core member is unable to attend they must send a deputy who authorised is to take decisions

There will be a tele-conference in the intervening weeks between meetings – at the two week mark between the core members and the programme lead

No decisions to making changes affecting the whole system can be made without the approval of all the core members

The programme lead will produce a report for each meeting on the programme progress by each work stream and any other reports requested by the Board meeting – all papers will be sent out one week before Board meetings

Governance

Each member is a senior executive of their own organisation and as such will take the responsibility to report regularly to their organisations Boards

The lead representative from each organisation will need to have the authority to make decisions on behalf of their organisation in relation to the programme

This Board will report bi-monthly to the Creating a Healthy Oxfordshire (CAHO) Board, and monthly to the Joint Management Group of the Older Peoples and Adults with Physical Disability Section 75 Pooled Budget. The Board will also report to the Health Liaison Board and to the Strategic Health Authority on request.

There will be an agreed matrix of cross governance with the QIPP Programme Boards as an appendix to the terms of reference

August 2011

To be reviewed February 2012

Appendix Two

When we get it right for Mrs Oxfordshire

She will have a local support system

She will feel safe receiving Treatment in her own home

Her home will be fit for her needs

She won't feel imprisoned In her home, she can get Out and about

She can manage herself or know how to get help for things of everyday life

When she become unwell services can go into her home. If she needs to go into hospital, it will just be to sort things out and she will then recover at home

She will know who to ring if things go wrong, and get a response and support quickly